HS-2004 PHASE II: FINAL REPORT

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MSH MANAGEMENT SCIENCES FOR HEALTH
a nonprofit organization strengthening health programs worldwide

HS-2004: Phase II
2000- 2005

Final Report

USAID FROM THE AMERICAN PEOPLE

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Letter from the Project Director

The HS-2004 Project/Phase II, a 5-year investment by USAID in the health of the people of Haiti, has channeled significant resources through processes that have:

- Supported the effective delivery of an integrated package of health services to a population of 2,875,762 via a Network of 94 service delivery points at both institutional and community levels.
- Strengthened public and private institutions that deliver them, through the implementation/strengthening of a "Minimum Management Package" that included financial management, health information, personnel management, drugs and commodities management and waste management.
- Contributed to the scaling up of HIV/AIDS services by providing technical and financial support to the implementation of 33 sites offering VCT/PMTCT services and 4 others providing anti-retroviral therapy.
- Contributed to increasing the cure rate of smear-positive (TB) cases from 48% in 1999 to 70% in 2002, and in increasing the number of sites offering DOTS services from 93 to 181 IN 2004. Among these, 144 were supported by HS-2004.
- Reinforced community participation and the linkages between communities and health service providers through more effective Behavior Change Communication and Community Mobilization interventions.
- Contributed to the MOH's decentralization effort with the launch and initial implementation of a departmental-based health planning process that promotes MOH's leadership and normative roles, as well as local empowerment, coordination, and public-private partnership.
- Allowed for effective and timely response to emergencies caused by natural disasters such as the floods in Gonaïves, Fond-Verrette and Mapou.

In this period, Haiti has been a place where problems have proliferated and social, political, and economic structures have undergone major, sometimes violent, changes. Natural disasters have taken thousands of lives without warning. The people and many local institutions in Haiti, however, have been resilient; coping with extraordinary hardships and impediments.

Some things stand out as bright spots in a chaotic view. HS-2004, in its second phase, has worked with a broad array of local health organizations, technical partners, and government colleagues to make progress in public health one of those bright spots.

The project supported the development of a vibrant Network of NGO and FBO service providers that collectively serves a third of the population of Haiti. The individual organizations provide a package of services according to MOH national guidelines, norms and standards; and support each other through an active cross-fertilization program and a well coordinated Monitoring and Evaluation system.

A performance-based system for contracting with these NGOs and FBOs has fostered innovation, motivated efficiency, and rewarded results. The HS-2004 focus on results has been instrumental in beginning a realignment of the market for health services in Haiti to focus on quality, access, and efficiency. In that sense, HS-2004 has been a catalyst and a leader in changing the paradigm for foreign assistance to the Haitian health sector.

Strategies that include both the public and the private sectors within each of Haiti's departments have been developed for effective drug management, management of infectious diseases, and promotion of maternal and child health.

The HS-2004 Team and its partners steadily adapted approaches, plans, operational structure and roles to (or in anticipation of) multiple and frequent changes in circumstance, priority and calamitous situations, while continuing to focus on USAID's Strategic Objective of "Healthier Families of Desired Size". This

tactic allowed the Project to adapt to the evolution of the local context, seize opportunities and always be on target for meeting real and current needs (rather than those defined in the past year).

In 2003-2005 HS-2004 team members, sometimes facing significant personal risks provided extraordinary services in maintaining support to health systems through the political and social tumult that led to the current interim government, and for relief and reconstruction of health systems and facilities in Gonaïves following the flood.

The President's Emergency Plan for AIDS Relief was launched in Haiti in 2003 and, in support of that initiative to combat the crisis of the HIV/AIDS pandemic, HS2004 worked closely with the MSPP and the US Government Team in Haiti to establish and scale up HIV/AIDS services within its network and to help coordinate the efforts of other cooperating agencies and US partners to meet goals established in the PEPFAR Country Operating Plans.

The partners of HS-2004 have been the primary players in the dramatic increase in service access and quality that has been realized over the past four years. It has been our honor to support the progress of the members of the HS-2004 Network and our pleasure to track their achievements.

Thanks are also due to the Minister of Health and her staff for their collaboration, openness and support for our joint goals, and effective leadership in the design and implementation of the Departmental Strategy launched in June 2004.

USAID's leadership and foresight in creating this comprehensive and dynamic project design and in maintaining attention, resources, and commitment to goals through numerous transitions have been pivotal. Without USAID's commitment to "Healthier Haitian Families of Desired Size", its funding and continuous support, HS-2004's results and positive impact would not have been possible.

The opportunity to collaborate with other cooperating agencies and donor agencies working in Haiti has also been invigorating and challenging.

It has been my privilege to be associated with this Project and the many organizations and individuals who have worked so hard to make it a success.

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Paul Auxila
Management Sciences for Health
HS-2004/Phase II – Project Director

PARTNERS

For Service Delivery

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INSTITUT HAITIEN DE SANTE COMMUNAUTAIRE - INHSAC
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TECHNIQUE – CFET

Subcontractors

HAITIAN HEALTH FOUNDATION
JOHN HOPKINS UNIVERSITY/JHU/CCP
PATHFINDER INTERNATIONAL

Health System and NGO/FBO base

Throughout Project implementation, resources and programmatic contributions of the US Government were well-coordinated to enhance impact, support sustainability, and reinforce the overall function of the health system. The market for health services in Haiti was strongly influenced by US government strategy with NGOs and Faith based Organizations (FBO) to focus on and fund performance.

Other donors were a positive factor and the commitment of significant funds through the Global Fund had an impact on Managers of FBOs, NGOs, and in the public sector. These service providers actively used performance monitoring data and supportive supervision to track adherence to standards and progress toward goals. Efficiency and innovation were rewarded through various performance-based incentives that promote sustained impact.

By the end of 2004, HS-2004 service delivery programs targeted a total population of 2,875,762 about 33% of the population of Haiti. Its Network of NGO sector partners included:

- 27 non-governmental/faith-based organizations
- 94 service delivery points offering the full integrated package, including 9 hospitals, 47 health centers, 38 dispensaries with their associated community programs.
- 31 sites offering HIV VCT/PMTCT services
- 4 sites offering Anti-retroviral therapy for HIV
- 148 physicians, 168 nurses, 423 auxiliary nurses, 1,035 community health workers and 3,992 trained traditional birth attendants
- 144 sites for TB diagnosis and treatment

With the Public sector, HS-2004 supported the National TB Program to establish coordination, mechanisms for expansion of service delivery at departmental level; worked with the national HIV/AIDS Program to establish a model of Governance and Coordination supported by seven technical clusters, and initiated a decentralized integrated health planning process with nine of the ten Departmental Directorates.

Context in Haiti (2000-2005)

In Haiti, during the years of this project, the economy was always troubled, the political system in turmoil, and the challenges to the health system punctuated by emergencies and natural disasters. Families and communities struggling to meet basic needs were often forced to endure threatening situations and overt violence. At the same time, there was increased understanding of the value of quality health services and the demand for access increased.

Following the disastrous flood in Gonaïves, the HS-2004 team added relief and reconstruction to their work plan.

Initially most of MSH interventions in Gonaïves were related to the emergency response: food, medicines, logistics, communication, technical support to the established health posts, supporting operating costs of the Ministry of Health, evacuation of cases requiring more sophisticated health interventions, and technical assistance etc.

Following the emergency response, HS-2004 continued to support the Artibonite Department:

- Assisting the MOH to implement a community program targeting 150,000 in the communities around the city of Gonaives.
- Helping secure and rebuild the Departmental Hospital "La Providence"
- Reestablishing the priority health programs especially at the community level, including TB and HIV/AIDS.


REPUBLIQUE D'HAITI
MISISTERE DE LA SANTE PUBLIQUE ET DE LA POPULATION

Honneur et Mérite

A

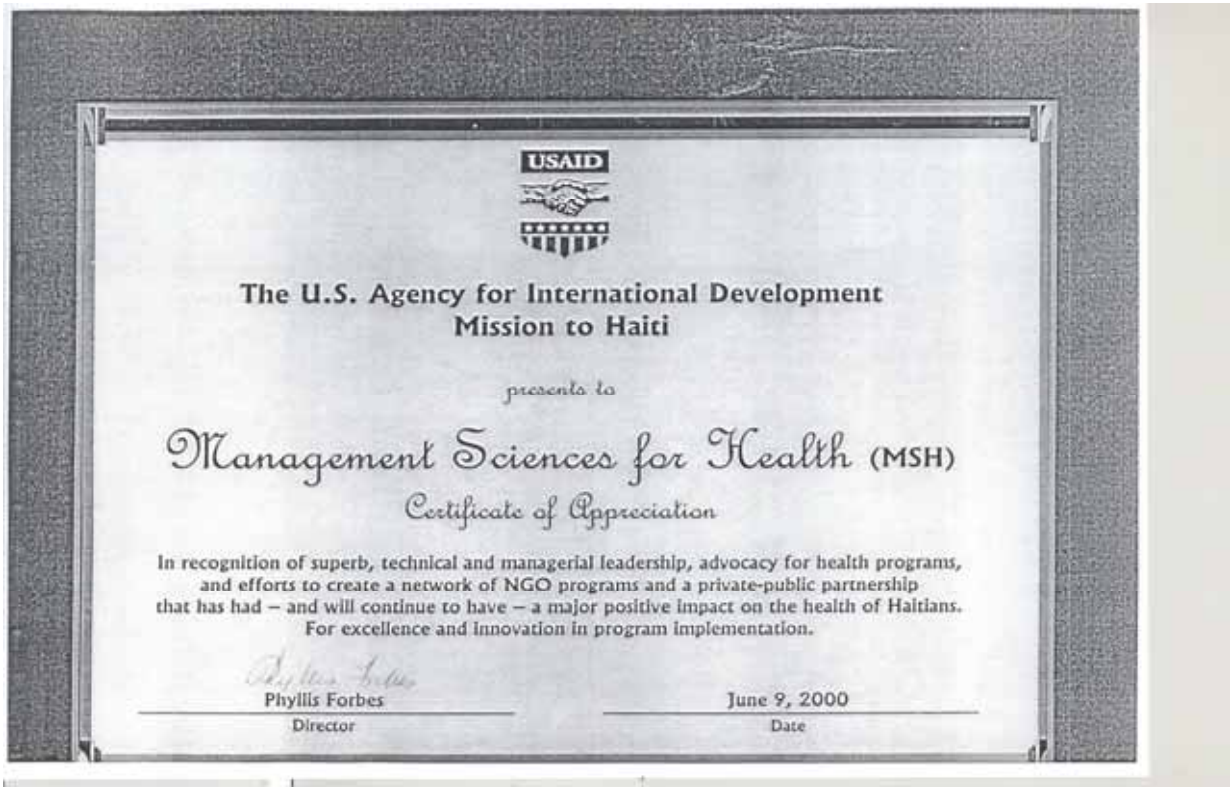
M S H

pour son humanisme et l'aide précieuse apportée aux victimes des catastrophes enregistrées dans les régions de Mapou, Fonds-Verrettes, Artibonite, Nord et Nord-Ouest d'Haïti.

Fait au Palais, le 7 mai 2005

Dr Josette Bijou
Ministre

The HS-2004 Team is proud to have been publicly honored by several of its partners. These include:



USAID

The U.S. Agency for International Development
Mission to Haiti

presents to

Management Sciences for Health (MSH)

Certificate of Appreciation

In recognition of superb, technical and managerial leadership, advocacy for health programs, and efforts to create a network of NGO programs and a private-public partnership that has had – and will continue to have – a major positive impact on the health of Haitians. For excellence and innovation in program implementation.

Phyllis Forbes
Director

June 9, 2000
Date

La Fondation
Promoteurs Objectif Zerosida
(POZ)

est heureuse d'offrir cette plaque d'honneur à

MSH

Pour son engagement dans la lutte
contre les IST/VIH/SIDA
et sa Contribution appréciable
en tant que partenaire de l'institution.

Mai 2005


LES CENTRES POUR LE DEVELOPPEMENT ET LA SANTE (CDS)
DECERNENT CETTE PLAQUE
Honneur & Mérite
A
MSH
EN RECONNAISSANCE DE 8 ANNEES DE FRUCTUEUSE
COLLABORATION ET D'ASSISTANCE TECHNIQUE
DANS LES DIVERSES PHASES DE LEUR
PROGRAMME DE SANTE AU BENEFICE
DE POPULATIONS DE 3 DEPARTEMENTS
GEOGRAPHIQUES DU PAYS.
PORT AU PRINCE LE 3 DECEMBRE 2004
DR REGINALD BOULOS
PRESIDENT DU CONSEIL D'ADMINISTRATION
DR PIERRE P. DESPAGNE
DIRECTEUR EXECUTIF

HS-2004 Project and its objectives

The Haiti Santé 2004 project was developed to advance the USAID Strategic Objective 3 (SO3), "Healthier families of desired size". The Project was designed in two phases. The first phase (1995 – 2000), provided a focus on the creation of a network of service provider organizations, both public and private; to deliver the Ministry of Health's Minimum Package of Services to clearly defined populations throughout Haiti. In addition, through a National focus, technical assistance was provided to both the Ministry of Health (MSPP), and specialized NGOs for the development of national health and population policies, national programs in immunization, reproductive health, child health, IEC, and institutional development.

Phase II (2000 – 2005), represented a significant change in design, with the MSH contract for the HS-2004 Project no-longer providing direct assistance to the public sector. The original intermediate results for the HS-2004 Project in its second phase were:

- IR 3.1: Increased Use of Quality Child Survival & Nutrition Services
- IR 3.2: Increased Use of Quality Reproductive Health Services
- IR 3.3:Youth Better Prepared for Responsible Family Life and Men More Engaged in Responsible Family Life
- IR 3.4: Women Empowered

Phase II was to continue an emphasis on coordination with the public sector, but its technical assistance and financial support was to focus on the NGO Network developed in Phase I , and the integration into that Network of other NGOs funded previously through other mechanisms. Assistance to the public sector was to be provided through a separate Strategic Objective Agreement (with focus on MIS, Essential Drug Management, and Finance & Administration) managed directly by USAID and implemented with other cooperating agencies.

USAID's IRs were revised in 2001 in response to significant changes in the Haitian context, available resources, policy, and the health environment in order to maximize results for the benefit of the people of Haiti.

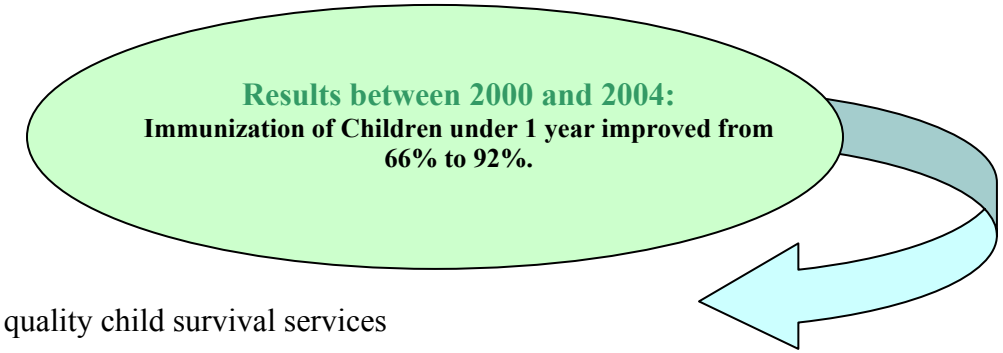
Major changes in program priorities were made at mid-term of the project, requiring a review of specific goals and priorities in the project contract. USAID and MSH agreed that the Project must preserve achievements with and expand the scope and impact of the NGO/FBO network while expanding the vision to be national in focus as it took on accountability for new technical program elements.

Nine additional priority areas were added at this time:

- Support Coordination of PEPFAR funded interventions
- Implementation of VCT/PTME and ART services
- HIV/AIDS (and VCT)
- Tuberculosis
- Commodities logistics (emergency distribution)
- Waste Management
- Increased collaboration with MSPP
- Increased emphasis on maternal health
- Expansion of focus to national programs and departmental level (while still working with the network as a group and individual institutions

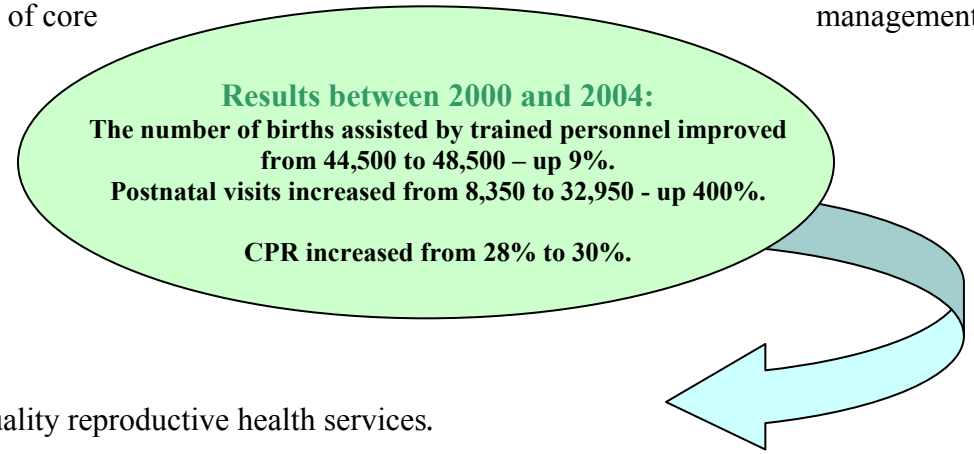
This program has been implemented with both careful attention to contractually specified technical goals and with recognition that flexibility would be essential to success. Through active collaboration with the USAID SO3 team, the Project has been able to adapt to changes in goals, priorities and activities as circumstances evolved.

Revised USAID/H Intermediate Results for Phase II



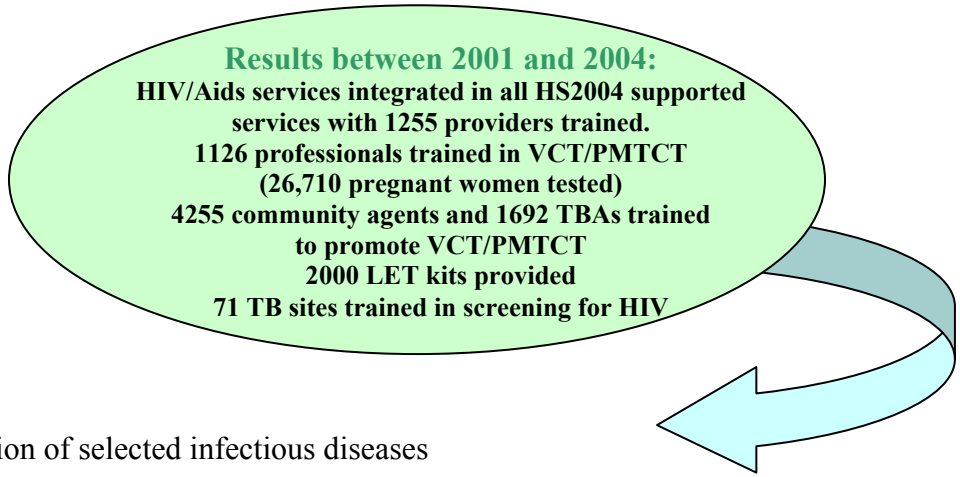
IR 3.1: Increased use of quality child survival services

1. Improved health reinforcing/care seeking behavior
2. Expanded availability of the minimum package
3. More effective interventions to decrease malnutrition
4. Improved performance of core management



IR 3.2: Increased use of quality reproductive health services.

1. Improved quality and effectiveness of R.H. education and behavior change communication
2. Increased availability of family planning and related counseling & referral services
3. Improved quality of clinical reproductive health services
4. Improved policy environment for the provision of family planning and reproductive health services.



IR 3.3.: Reduced transmission of selected infectious diseases

1. Effective HIV/AIDS prevention-to-care strategies adopted
   And implemented
2. Expanded availability and use of the syndromic approach to STI
3. Improved detection and management of TB cases
4. Strengthened disease surveillance systems and related laboratory and diagnostic infrastructure.

Summary results of HS-2004
Structure of the minimum package services and management

Indicators	Baseline (1999)	Final HS-2004/II
Services included in the minimum package of services.	**Child survival :** 1- Immunization 2- Prevention of dehydration caused by diarrhea 3- Growth monitoring 4- Supply of Vit A **Reproductive Health** 1- Reproductive Health 2- Family planning 3- Prenatal care 4- Assisted Deliveries 5- Postnatal care 6- STI prevention	**Child survival :** 1- Complete immunization of children under one year (six major diseases) 2- Prevention of dehydration and diarrhea disease care management 3- Nutritional surveillance and recuperation 4- ARI prevention and care management **Reproductive Health** 1- Family planning (at least 4 modern methods per site) 2- Prenatal care 3- Assisted deliveries at both institutional and community levels **STI/HIV/AIDS/TB** Comprises the related interventions & services for prevention and management of STI including HIV infections 1- VCT 2- PMTCT 3- ART 4- Management of OI 5- Laboratory **Tuberculosis** 1- Screening and detection 2- DOTS 3- Laboratory
Service Delivery Support System included in the Minimum Package of Management.	- Not available	1- Health information system 2- Human resources development 3- Financial management 4- Commodities and drug management 5- Infection prevention and waste management

These two columns of this table are being provided for illustrative purpose. It is however important to be cautious in their interpretation for the following reasons.

- The methodologies applied to collect the data are different. In 1999, a community-based survey was done in (HS-2004/Phase I) project areas, and data was collected based on available record and client's recollection. By 2004, institutions had significantly improved their information systems and project data is based on validated service statistics which represent more accurately their contribution. Throughout Phase II implementation, a significant investment was made in information system to improve availability and quality information. For example in 1999, prenatal visit meant: the number of prenatal visits during pregnancy. However, in Phase II this indicator was revised to indicate: the number of prenatal visits according to MOH norms (that is the first visit must be in first quarter, including Para clinics).
- We should also note that Reproductive Health (RH) services (beyond FP) were introduced in the new partners services by the end of 2001.
- RH services were also adversely affected by a national stock out of Tetanus Toxoid vaccine and Iron Folate caused by donor withdrawal. As a palliative, the DT (adult) was proposed by the MOH and not accepted by providers (as pamphlet clearly states that is not indicated for pregnant women).

Summary results of HS-2004

Overview of the project

Indicators	Baseline (1999)	Final HS-2004/II
Total population in the area of HS2004	2, 039, 360	2,875, 762
% of the population covered by HS2004	26,6 %	33,6%
Number of NGOs involved in providing services to the population	17	27
Number of Rally points	…	2,222
Number of Health Agents	…	1,035
Number of trained TBAs	…	3,992
Number of institutions involved in Performance Based Financing	3	12
Number of TB sites in all the country	156	224
Number of DOTS sites in all the country	93	181
Number of DOTS sites supported by the project	N/A	144
Percentage of DOTS sites supported by the project	N/A	79.5%
Number of VCT sites implemented and supported by the project	1	33
Number of ART sites implemented and supported by the project	0	4
Number of health departmental offices that receive technical assistance from the project	0	9
% de sites with distribution points of ORS in the community.	85.1%	90.4%
% of sites providing treatment of acute respiratory infections (ARI) cases	…	87,2%
% of sites providing at least 4 modern methods of Family Planning	40%	95.7%
% of sites using Syndromic approach for STIs	35%	96.8%

…: not available
N/A: not applicable

Summary results of HS-2004
Specific results

Indicators	Baseline (1999)	Final HS-2004/II
Percentage of children 0-11 months fully immunized	56.2%	92.0%
Estimated number of children under five years old receiving services of growth monitoring.	…	211,473
% of weights with weight/age less than two standard deviation (<2SD).	21.8%	18.0%
Number of ARI cases treated in the service delivery points	…	44, 409
Percentage of pregnant women that received at least 3 prenatal care visits	61.0%	48.0%
Percentage of mothers who had been assisted by a trained personnel during the delivery	78.0%	63.0%
Contraceptive prevalence rate in women 15-49 years old	23.4%	30.0%
% of postnatal home visits	0	42.0%
# of young acceptors under 25 years new to Family Planning	…	30,555
# of male acceptors over 25 years old new to Family Planning	…	14, 916
Number of persons tested for HIV	0	38381
Number of pregnant women tested for HIV	0	26, 710
Number of new TB cases detected in all the country	N/A	14579
Percentage of new TB cases detected in the area of the project	72.5%	75.0%
Number of AIDS patients receiving ART	0	104

…: not available
N/A: not applicable

Highlights

Performance Based Financing (PBF) – a focus on innovation, accountability and results

The HS-2004 PBF mechanism implemented with 3 partner institutions in early 2000 was extended to a total 12 HS-2004 partners by 2004.

At the HS-2004 Project's inception services were being provided primarily by NGOs with funds transferred to them on a cost-reimbursement basis.

The various numerous NGOs in the Network had been able to provide enough services through this mechanism to have a positive impact on major health indicators over the previous years, particularly in infant mortality reduction rates. However, there were wide variations in performance and no correlation between performance and costs.

The problems associated with the cost-reimbursement system were clear. With all expenditures reimbursed, there was no real incentive for efficiency or to improve management and operational systems. Furthermore, technical assistance was mostly imposed as many partners did not have realistic assessments of their strengths and weaknesses. With no contractual link to results, there was little or no incentive for improved quality or expansion of service coverage. These organizations were and are mission driven, but results and costs varied enormously

USAID wanted to shift to a new system that would promote and reward results rather than activities. MSH proposed an approach for working with these NGOs and FBOs as contracting partners and accepted responsibility for achieving program results entirely through the work of these NGO/FBO partners. This new approach was introduced as a "Performance-Based Financing" mechanism whereby each service delivery partner had to negotiate a subcontract with goals, program boundaries or limits and well defined technical assistance plans).

Each NGO negotiated and agreed to specific subcontract indicators and performance targets. Each also accepted major new elements in the financial contract: incentives as well as risk of not being paid certain percentage if objectives were not met.

Information from the monitoring system on NGO performance (both cost-efficiency and service data) were shared across the Network. NGO managers not only worked with their own budget and service delivery systems, but have also been able to understand where they are performing well in relation to other NGOs, their contract's objectives and where improvements should be made. Regular network meetings and an aggressive cross-fertilization program encouraged sharing of best practices in the challenging Haitian environment. The network effect enabled NGOS to support each other.

Rough estimates of average costs per visit based on performance data ranged from $1.35 to $51.93). Some NGOs with high estimated average costs per visit were relatively poor performers, while other low cost NGOs achieved more impressive performance targets

The incentive was that, if all goals were met, there would be additional performance incentive payments. These were pre-negotiated when the objectives and indicators were defined and the contracts formulated. NGO partners welcomed the flexibility that this new contracting approach provided and the potential for obtaining performance incentives, all of which would be available for discretionary allocation by their management. But, failure to meet any individual target would result in a reduction of the potential incentive payment according to a pre-specified formula agreed upon with each NGO.

These NGOs saw an immediate need to adapt management behaviors to do more and better, to plan in a more realistic and results-oriented perspective from their headquarters to service delivery points, to implement supportive supervision systems, and to strengthen their capacity to produce and use valid and timely program information. This strategy also created a more demand-driven technical assistance program.

When a potential for failing to meet incentive targets became clear, individual staff members of the NGOs had information that enabled them to consider changes in approach. The NGO managers were able to consider alterations to systems, reallocation of resources, or fundamental strategy changes.

Results have been impressive. In 2004 for example, network immunization rates, for the first time, exceeded 90% and post-natal care finally became a routine service within the Integrated Service Package. There have also been dramatic improvements in management efficiency, such as: more decentralized planning and increased delegation, implementation of more reliable and timely information systems, implementation of well defined personnel management policies and procedures, and sound and auditable financial management.

Strategic evaluation reports from individual NGO managers and staff have indicated high satisfaction with the program and observed that the processes of monitoring, identifying problems that could impede performance, and devising corrective action plans have had a positive impact on motivation and performance. Capacity for strategic planning has been upgraded, demand for and effective use of M&E for performance enhancement has become generalized, data validation mechanism have been put in place resulting in an increase in data quality, improved systems for supervision and human resource management have been established, and awareness of the potential of incentive systems for promoting innovation and impact has been accepted.

The need to track progress toward targets led to a general strengthening of the internal need for and valuing of M&E systems. The service data were collected in order to monitor efficient use of resources and program performance and impact. In some cases, this has been the first time that service data have had an internal use in program planning and system innovation.

Lessons learned

Introduction of PBF has dramatically changed the way NGOs are managed. It has fostered innovation, accountability, decentralization and performance.

Focusing contractual requirements on results rather than on processes allows a program to maintain progress toward strategic goals and promotes the collection, validation and use of performance data.

Incentive prospects generate motivation to both track and understand the reasons for progress (or the lack thereof) and promote innovation in strategies and systems to address local constraints or national/departmental systemic issues.

Even in cases where an indicator target has been missed (and no incentive, therefore, is received), the NGOs have used the experience as an investment in improvement.

Since internal system and strategy changes are 'self-developed' and then specifically rewarded when they are effective, these changes may be better sustained by NGOs after the end of the project period.

There is the potential for an indicator selected to represent a range of important areas of activity to distort overall program efforts (causing relative lessening of effort in areas not being assessed as incentive indicators).

The sharing of performance and impact data is a powerful influence on how the market for services operates. In the context of an incentive program aimed at improving access, quality, and efficiency, the competitive pressure positively impacts the establishment of accepted standards.

The following table illustrates the impact of the PBF strategy in immunization rates and prenatal care for eight NGOs:

ONG #	Percent of Incentive Earned (achievement of All Targets)							Indicator change during P-B C partic. and Years in program		
	P. 1 11/99 3/00	P. 2 4/00 9/00	P. 3 10/00 9/01	P. 4 10/01 12/01	P. 5 1/02 12/02	P. 6 1/03 12/03	P. 7 1/04 12/04	Immunization	3 prenatal visits	Years
1	70	85	90	100	70	40	60	49.2 to 88.0	49.3 to 36	5
2	80	85	70	100	60	63.5	75	39.7 to 90.0	32 to 72	5
3	40	75	90	90	30	52.5	60	34.7 to 98	18 to 98	5
4			80	100	55	62.5	55	37 to 84	17 to 57	4
5			70	90	10	80	60	73 to 88	38 to 88	4
6			80	81	80	40	80	54 to 102	25 to 76	4
7					78	85	50	50 to 107	44 to 54	3
8					48	55	NA	78 to 71	36 to 40	3

Highlights 2001 - Network rationalization

In order for HS-2004 to respond adequately to the significant expansion of its mandate, as represented by the amendment of its intermediate results and goals, without any increase in financial resources, a serious exercise of "rationalization" targeting increased service delivery efficiency was of paramount importance. The team reviewed information obtained from the application in each partner organization of the SDAP (Service Delivery Assessment Protocols), MOST (Management and Organizational Sustainability), CORE (Cost and Revenue Analysis), financial verifications/audits, along with insights gained through technical assistance, training, and field visits to summarize the Network partners' current performance and potential for improved performance and impact. Network partners were grouped into five categories (before costs were considered):

1. Those requiring no special attention for continued funding
2. Those continuing to need technical assistance
3. Those with serious leadership, management or attitude issues
4. Those that should be put on probation:
5. Those whose contracts are or should be cancelled

Looking at cost considerations:

- Partner estimate of budgets per capita and degree of correlation between budgets, geographic coverage and services offered (real costs of the PSPI were not yet determined).
- Other sources of Partner funds.
- Excess management and administration cost structures (burden to service delivery).
- Resource allocation related to production of services and quality of care (SDAP results).

Results:

- A focus on reduction of costs in the five institutions with the highest per capita/service costs using a zero-based budget process. (The SDAP established that the high costs were not a consequence of more or better services).
- For the remaining institutions with "unit costs" higher than the average, the inclusion in contracts of objective linked to the development of a service cost strategy with a target of 7 % reduction by September 2002.
- The developments and implementation of tailored technical assistance, training and supervision plans with each Partner.
- A 10% budget reduction was achieved for 5 partners with no reduction in services provided.
- The Cancellation of contracts with non-performing service delivery partners.

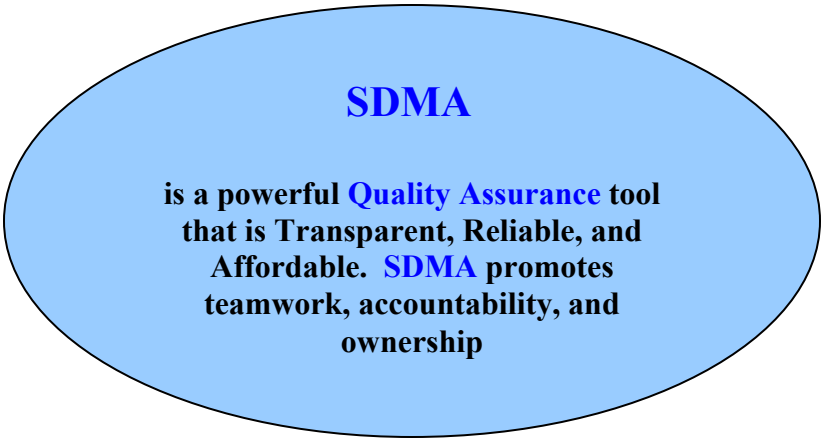
- A systems and cost structure review to identify opportunities for increasing efficiency was carried out with all partners.
- Budgeting system and procedures were reviewed and a standard was set to separate budgets and plans for hospitals and community programs.

Highlights 2002

SDMA – Technical assistance and training tailored to each partners specific needs:

The two tracks for monitoring performance of HS-2004 service partners, the SDAP (Service Delivery Assessment Protocol) and the PMG (Minimum Management Package Review) had been effective. But it became clear that the best approach to tracing both quality and efficiency of service provision would be to combine these protocols into a single process that, if designed correctly, would assess both the quantity and quality of services provided as well as the effectiveness and efficiency of the management systems that support those services.

The SDMA (Service Delivery & Management Assessment) process was then developed and launched in collaboration with service partners as a transparent, collaborative, and reliable mechanism for assessing Partners organization, quality of services, and management system. The implementation of the SDMA helped assure reliable monitoring data, promote a market for services based on quality and efficiency, and secure accountability.



Objectives of the SDMA:

- Evaluate improvement and progress toward service delivery goals
- Recognize the effectiveness and value of services provided by organizations at the community level
- Validate the effectiveness of partner organization management systems at the central and local levels (drug management, human resource management, information management, financial management and waste management).
- Identify problems and find solutions in a participatory manner

- Establish technical assistance plans tailored to each institution's specific needs
- Identify opportunities for cross fertilization among partners**.**

Approach: The HS-2004 team worked with service partners to assemble assessment teams that were composed of project staff and when possible, representatives of USAID, MOH and service partners (Partner representatives did not assess their own organizations). The protocol itself provided a consistent structure for inquiry and analysis. Routine service reports were validated against clinic records. Clinic records were tested for accuracy through sampling and verification though interviews with clients. All service points were visited by the teams on a schedule allowing four days per institution. The analysis and reports were generated on-site at the end of the site visit along with an action plan for improvement. Where serious problems were encountered, a correction plan was jointly developed that eventually led to either a properly realigned system, re-negotiation of contracts objectives or termination of service contract.

Results:

- HS-2004 achieved a reliable database for tracking project impact and results.
- Accountability for service standards and accurate reports was established.
- Exchange of data across organizations resulted in significant cross-fertilization and strengthened the market focus on performance.
- Multi-disciplinary team action improved collaboration and technical understanding across specialty areas and across the Network of NGOs.
- Clear understanding of progress and results allowed for effective adaptation of HS-2004 technical assistance and training plans to build on achievements, focus efforts on gaps and problems, and identify partners who could complement MSH's technical assistance.
- Analysis and conclusions from the SDMA (Service Delivery & Management Assessment) guided the technical assistance as well as the training program for the remainder of the Project.
- The SDMA tool was adapted and used by other partners, NGOs and more recently applied by the MOH.

Highlights 2004

HIV/AIDS and PEPFAR – 31 VCT/PMTCT sites and 4 ART sites made launched and operational

In 2004, HS-2004's mandate was revised to include the implementation of HIV testing, care and treatment and to integrate these with other services, including tuberculosis. In cooperation with its partners, HS-2004 reviewed its previous strategy that until then only focused on STI care and HIV prevention. The PSPI was reviewed to promote a holistic approach which focuses on the patient as a whole, ensuring effective integration of other program elements and adequate management support. This revised strategy aimed to:

- Strengthen the capacities of all institutions of the network to implement voluntary counseling and testing services and health care services for HIV-infected persons in compliance with the national norms (including counseling, rapid testing, and health care for tuberculosis, other sexually transmissible infections and opportunistic infections).
- Implement in all institutions within the network, an integrated program of prevention of mother to child transmission of HIV.
- Support four institutions to provide anti-retroviral therapy.
- Strengthen the management capacity of the Central Unit for Coordination of the HIV/AIDS Program (UCC), of the departmental directorates and of the main partners who are direct service providers, to effectively implement the national HIV/AIDS strategy.
- Increase the availability of testing and health care services for STI/HIV/AIDS and tuberculosis.
- Promote the decentralization process and public-private sector partnership.

Details on Specific Objectives and Results appear later in this report. A sampling of results include

OBJECTIVE: Increase availability, access and use of child health and reproductive health services, and their integration with HIV/AIDS care.

RESULTS

- 31 sites are providing integrated VCT/PMTCT services within the network; and 26,710 pregnant women were tested
- 436 HIV+ women enrolled in PMTCT programs

OBJECTIVE: Strengthen the capacities needed to ensure HIV voluntary counseling and testing services at all the institutions of the network

RESULTS

- In addition to the 31 sites able to provide VCT/PMTCT services, two non-clinical sites are providing counseling and testing services
- These services are organized using as reference the "Operational Manual for the Implementation of VCT/PMTCT Services"
- Financial support is provided to two mobile supervision mobile teams through the GHESKIO Centers.

OBJECTIVE Deliver adequate care (in compliance with the national norms) to affected and infected patients and to HIV+ pregnant women under the "Prevention of the Mother to Child Transmission" framework.

RESULTS

- Guide developed and disseminated for the Care of HIV+ pregnant women and newborns developed and…
- Adaptation of the Guide for community workers and integration into their curriculum in Creole.
- Training of first line auxiliary nurses for safe deliveries.
- Regular provision of delivery kits for the trained TBAS.
- 5027 community agents and TBAs trained

OBJECTIVE: Improve the quality of prevention of transmission from mother to child services (PMTCT).

RESULTS

- Training/refresher courses on counseling for 66 providers.
- Technical assistance plan, to improve the quality of services and management systems.

Launch of the Departmental Strategy – An increased focus on decentralization, departmental level coordination and public-private partnership

Following the natural disasters in Fond-Verrettes, Mapou and Gonaïves and discussions with USAID, the HS-2004 team developed a strategy with the MSPP to strengthen public sector capacity to guide the overall health system at the departmental level, and to promote synergy and coordination of interventions of FBOs and NGOs with public sector health services within the national health policy framework.

The goals of this initiative were not only to support the MSPP in its effort to decentralize but also to support the departmental leaders in their efforts to capitalize on resources already available (but scattered), plan and coordinate activities targeting public-private partnership, and expand coverage and improve quality of services. The mandate of HS-2004 was to assure technical and administrative leadership for the planning, coordination and implementation of assistance activities in health supported by USAID at the departmental level.

Initial focus of work with the public sector was on the elaboration of department-wide strategies and work plans to:

a) Extend TB DOTS and strengthen, with PNLT, activities to better manage TB
b) Implement plans for VCT/PMTCT and support for People Living with HIV/AIDS
c) Improve drug management
d) Improve immunization coverage in collaboration with DPEV
e) Improve access to family planning services and modern contraceptive methods
f) Increase BCC efforts targeting reduction of maternal mortality and management of obstetrical emergencies

In spite of the difficult circumstances that coincided with the launch of this strategy (political upheaval, transitional government, and natural disasters), most planned activities were successfully carried out. (Some problems however did have a slowing down impact (for example lack of follow though by some donors on promised funding and misunderstanding by some departmental leaders of USG procurement regulations.)

Although this strategy is still in its beginnings, these 'departmental plans'(a) were instrumental in building trust and developing an effective partnership between USAID's health program and the MOH at departmental levels, (b) provided HS-2004 with the opportunity to assist the MOH in establishing minimum working conditions and appropriate basic infrastructure at departmental levels; (c) energized and increased motivation of the public sector departmental staff; (d) made possible the implementation of quarterly departmental planning and work sessions in which plans are reviewed, progress and priorities are re-assessed and planned interventions are revised, (e) have

begun to introduce accountability and a demand for results not only within the public sector but also within the NGOs and the donor communities, (f) reactivated essential priority programs, (g) and finally, created a unique opportunity where the Haitian Government, with USAID support, is extending this strategy to all departments (and all programs), with a focus on promoting local governance and empowerment within the health sector, coordinating partners interventions, improving public-private partnership, and increasing access to services by vulnerable and under-served populations.

Lessons:

In an environment characterized by economic hardship, political instability, national conflicts, and an exodus of human resources, the Integrated Departmental Strategy approach has shown to be a catalyst for harnessing local capacity, developing leadership and governance, improving decentralized planning and coordination; and most importantly promoting local participation, public-private partnership, decentralization, and empowerment.

Immunization – *an interesting example of the impact of the Performance-Based Financing Program and the Departmental Strategy*

Economic and political instability do not define the potential of a society

MSH works in Haiti with a network of 34 Haitian NGOs (including 27 partners for services and 7 for technical assistance), half of which are 'Faith Based.' Together they serve over 3 million people, 1/3 of the national population.

Through internal systems reinforcement for empowering the local level and managing vaccine supply and adopting a strategy of having immunization services available at all clinics all the time, the network achieved an immunization rate of 92% in 2004

In the final year of HS-2004, the NGO network achieved an immunization rate for children less than one year of 92%. It is remarkable that this year marked the most major social upheaval in many years and saw two major flood disasters that killed thousands of people and required huge reconstruction and clean-up efforts. The system for stocking and distributing vaccines was not strong. What happened is that the individual service organizations were tracking their progress against their performance goals (which for vaccination were set high at 83%) and, whenever it seemed likely that a stock out might disrupt services, the program leaders worked internally with their teams to devise strategies for securing the necessary supplies. These sessions often produced innovations that improved program performance by alerting staff to the possibility of locating vaccine supplies on their own.

Program Elements

Service Delivery

The essential HS-2004 intervention in Service Delivery has been the technical and financial support provided to the NGO Network for the implementation of a "Priority Package of Integrated Services" or "PSPI" (Paquet de Services Prioritaires Intégrés). The PSPI was a practical adaptation of the Minimum Package of Services (PMS) that had been previously defined by the Ministry of Public Health and which had faced difficulty in its application.

The PSPI is composed of essential preventive and curative health services in child health, reproductive health, and infectious diseases and sexually transmitted infections, including HIV.

In the context of HS-2004, Phase II, these interventions have contributed to increasing access of the population to health care, and expansion of services with the effective participation of communities to assure themselves of the integrated availability of the PSPI in health institutions and at the community level. Access to health services in Phase II of the Project was strengthened through a geographic expansion of service areas with the HS-2004 network expanded to include several institutions that now offer the full PSPI, while they only offered family planning services when they joined the Project. In the 'rationalization' process, the quality of services provided by then-current partner institutions was assessed and corrections were made as needed with technical assistance provided by the Project.

HS-2004 promoted a holistic approach to care and the PSPI includes three major categories of services that are linked to effectively manage the health of its target population. The service providers at all network institutions are trained to offer the full range of services as a package (one-stop shopping) to clients as they arrive at the service delivery point and with counter-referrals to community support groups.

Use of SDMA

In Phase II, emphasis was put on the improvement of service quality in line with the MOH-approved guidelines, norms and standards, and with linkage to institutional development. Assessment activities were always carried out in collaboration with partners, using an innovative tool known as "SDMA" or Service Delivery and Management Assessment tool.

Analysis of the data collected through the SDMA allowed identification of weaknesses and gaps as well as documentation of strengths and achievements. The quality of services delivered was linked directly to the management systems that support service delivery. This linkage allowed the project team to target Technical Assistance training and resources efficiently.

HS-2004 vision was to maximize the use of local technical competencies to accelerate progress and achieve a durable sense of ownership among the network organizations. The application of the SDMA made it possible to identify partners with best practice in several domains of the PSPI and to integrate them into a cross-fertilization and technical assistance program. This exchange across technical and management support groups and also among Network institutions was a strong force for recognizing and enabling replication of successful innovation, promoting exchange between service organizations, and establishing a sense of 'performance standards' among service managers.

A support committee was established for the *Programme des Matrones*. This committee, CAPEM (*Comité d'Appui au Programme d'Encadrement des Matrones)* includes TBA supervisors from the HS-2004 Network (at least one per department). It includes, for example, representatives of CBP, HHF, MEBSH, MARCH, SAVE, Claire Heureuse, CDS, Fermathe and Le Prêtre. Along with the Network partners, 907 new TBAs were trained and the system for monitoring and re-supply 2065 others was strengthened.

The experience of CAPEM allowed the project to have early understanding of problems in coverage of maternal health services and to offer timely solutions. CAPEM resources were a major advantage in many field locations in the process of promoting the PSPI and improving health coverage in general.

GASCOM, (*Groupe d'Appui a la Santé Communitarian)* – was developed as a mechanism for discussion and information exchange on community programs being carried out in Haiti. Regrouping experienced community program leaders from the Network, its goal was to formalize strategy review and identify successful initiatives to reinforce community participation. GASCOM facilitated the development of a common definition for effective and appropriate Community Services and developed a guide to orient service providers in generating community health programs. This guide is still used as a technical reference throughout the Network.

Child Survival

Interventions in this area included allocation of specific objectives to service delivery points, with particular attention on relating these goals to the specific situation of the population served. Target groups were registered and monitored. BCC and community mobilization efforts designed to educate families and assure that communities in general were built in as part of the health service delivery system. Other program elements included training in child survival protocols, supervision, and use of service data to track progress and focus attention on results and resources. The impact was an increased availability and use of CS services and an observable improvement in quality.

Some general lessons reported by service delivery partners included reinforcement of the need for secure stock of essential drugs and vaccines, the importance of community involvement to reinforce education and behavior change, and supervision. An interesting result was the recommendation that income generating activities and low-cost

transportation support (bicycles and motorbikes) be built into community engagement efforts.

Vaccination

At the beginning of HS-2004 Phase 2, full immunization coverage of children under one year within the HS-2004 network of NGOs was approximately 56%. The program had been impeded by regular stock-out of essential supplies and breakdowns in the cold chain required to preserve the utility of vaccines.

HS2004 improved the availability of drugs and essential supplies through a system of '*déblocage'* for network institutions to help assure that available supplies were efficiently distributed to points where they were needed. This system was replaced in 2004 by a logistic support system at a higher level (to Departments) that served both public and private sector service delivery points.

There was an evaluation of the cold chain system in the Network that identified weaknesses that led to stock interruptions. Local personnel were trained in cold chain maintenance and the necessary tools and equipment were supplied. A protocol for cold chain maintenance, developed with DPEV has been adopted for use in both the public and private sectors.

The tools and processes needed for data collection and monitoring of vaccination programs were provided at each service delivery point (including registers for vaccinations, rally posts, home visits, and '*carts chiming la santé'*. Data were collected monthly and analyzed on a quarterly basis to track progress and focus efforts on areas with weak coverage.

Nutrition

The HS-2004 team emphasized nutritional surveillance and recuperation of children identified as having moderate or severe malnutrition. A total of 1035 health agents in the Network who had previously provided only support for family planning were trained to assure nutritional surveillance, supply vitamin A, and offer the integrated service package. As a result, 211,475 children under five received services of growth monitoring to assess child nutritional status and enroll them as necessary into a recuperation program.

The "*Ti Fwaye"* strategy was introduced in 10 institutions and, based on the success of that experience, was expanded to all Network partners, 57 *auxiliaires* were trained in a two-week program to be able to monitor and provide support to animateurs and mothers clubs. A practical guide was developed with participation of all partners involved in this program. This strategy resulted in the nutritional recuperation of 18,360 children.

A total of 3726 mothers and caretakers were trained in preventative care strategies for child survival and maternal health and organized to disseminate health messages, and channel community members to appropriate health services. These mothers and caretakers also serve as role models for young mothers and for community involvement.

In addition, a formal partnership was developed with food aid agencies such as Food for the Poor to provide powdered milk (750 sacks were provided to the network), and with the World Food Program who transferred the management of food distribution programs to three HS-2004 Network partners.

Diarrheal Disease Control

In response to the lack of availability of ORS at the national level, the Project took initial action to form a partnership with PSI to provide Network institutions with *Sel Lavi.* As a result, community points of sale have been supplied in relation to the needs of the population. Partner institutions also benefited from the reinforcement of procedures for management of re-hydration corners and training of staff on re-hydration techniques, practical demonstration and re-hydration kits.

Acute Respiratory Infections

In partnership with MOH, the institutions in the Network received training in ARI and then were provided with material, equipment, and data collection tools. As a result, 44,409 cases of ARI were treated in Network institutions.

Maternal Health

At the beginning of phase II of HS2004, the maternal health program effort was limited. An evaluation was conducted to identify main obstacles to the use of maternal health services (with a focus on pre-natal services). Access (both geographic and economic) was limited by a lack of appropriate, culturally-sensitive and affordable services at the local level.

Prenatal Care

Organization of technical workshops to reinforce the knowledge of field staff and provision of tools for collecting service data at the institutional and community levels were program focus activities.

- A protocol for prenatal case management was developed in collaboration with the MSPP and then produced and disseminated.

- A guide was developed to facilitate operational planning for routine activities and extending prenatal services at the community level.

- Partner meetings were organized to orient service staff on the use of materials and resources in the field to support prenatal activities.

- "*Déblocage*" of the supply-line for essential drugs and supplies to service institutions was provided to reduce stock outs.

- For Service points with weak prenatal coverage, additional personnel were made available to reinforce institutional activities (mobile clinics, fixed service points, home visits)

- Capacity development was provided to service points to augment provision of basic laboratory services to pregnant women at an affordable cost.

- Partnership was sought with food aid agencies (Food for the Poor and PAM) in order to provide nutritional supplementation to pregnant women and to certain institutions not covered by the existing food-aid programs of USAID.

- Improved availability and quality of related services statistics helped rationalize overestimated performance of previous years, particularly in the institutions that joined the program in 2000.

- Organization (in 2002-2003) of "campagnes de sensibilisation" around Mothers' Day to promote maternal health services and related behaviors

Assisted deliveries

Given that close to 80% of women in Haiti deliver at home, the Project emphasized the strengthening of the programs for "*matrons"* that had been neglected over the past few years by the MSPP partners. In 2004, 63% of deliveries were assisted by trained personnel.

Key interventions included:

- Development in French and Creole of a methodological guide for *Matrons* Program for use by different categories of providers.

- Training of 27 clinical trainers and 104 supervisors of "matrons" across the Network who were then able to develop programs within their own institutions, replicating the training they had received and assuring support to the focus activities.

- Organization of practical training sessions in delivery techniques for clinicians responsible for training of trainers in normal deliveries and for case management of obstetrical emergencies. This effort allowed the training during phase II of HS2004 of 3992 *matrons*, who were then given access to periodic sessions for skill maintenance and reinforcement along with re-supply of essential materials.

- Provision of delivery kits to service points where they would improve the capacity for case management of some minor complications.

Postnatal Care

In 2003, the project initiated a program to strengthen postnatal care within the network (including provision of necessary tools and materials). A check-list was developed with and validated by the partners, and disseminated for inclusion in the registries for home visits made by health agents. By 2004, 42% of mothers had received post natal visits.

Family Planning

The increase of CPR within project areas is one of the success stories of this program. In fact, significant progress was made in family planning through the following interventions:

- A protocol for management of side-effects was developed in collaboration with MSPP and disseminated along with essential tools and materials.
- The project put in place a system to provide institutions with supplies during situations where stock outs would otherwise take place.
- To improve quality, a protocol for the management of side effects due to hormonal methods was elaborated and disseminated. Technical assistance was also provided to reduce dropouts.
- All partners were required to offer at least four (4) modern methods.
- The extension of family planning services at community level and the introduction of community mobilization interventions to increase demand.

Despite these achievements at project level, it must be said that The Haitian Family Planning Program continues to face significant challenges: (1) weak national leadership; (b) rigid system for re-supplying providers in family planning commodities, (c) limited access to and uptake of long-term methods, and (d) frequent stock outs in the national pipeline for family planning commodities.

VCT/ PMTCT

HIV - VCT and PMTCT services were introduced in the last two years of the project and integrated into the PSPI. The following interventions were implemented:

- Organization of a technical workshop to plan integration of VCT and PMTCT into the PSPI. (With the staff of 16 service delivery sites).

- Essential supplies (including Nevirapine) were routinely provided to approved sites.

- A Pre and Post test counseling guide (including an M&E format) was developed by GHESKIO and, after review by MSPP and partners, revised and distributed.

- Workshops were organized in the field to introduce the VCT/PMTCT integration and develop strategies and plans with providers and communities.

- A practical guide for the integration of VCT and PMTCT services at the institutional and community levels was developed and disseminated. It is now used as a reference.

- Two new chapters were developed for the '*Guide méthodologique d'entrainement des matrones*' focusing on HIV/AIDS (1) and VCT/PMTCT (2) describing the essential role of the *matrones* in the education of pregnant women regarding the program and referring them for counseling and other services.

Support to Central Programs of MSPP

During Phase II of HS2004, the project team provided significant support to the National Immunization Program (DPEV). An activity plan was developed jointly with DPEV staff to focus on the improvement of logistic systems for drugs and supplies and on cold chain maintenance.

An intensive activity plan was developed and implemented for participation in "*Semaine des Amériques"* and vaccination campaigns. (One particular focus was targeting control of the diphtheria epidemic in the West Department).

Technical and financial assistance was provided to accelerate the implementation of vaccination activities to combat diphtheria in 17 communities along the Haiti/Dominican border. The project also furnished essential materials and information technology/communication equipment to the DPEV.

Community

Interventions based on inputs from the community and then designed by that same community for local use were a priority of the HS-2004 project. One of the goals was to establish and then build up synergy between community groups and the service delivery institutions. The following activities represent a partial description of the program:

- Development of a plan to organize services at the community level. This plan was used by the project training unit as a base component in the development of a staff training curriculum.

- Within the goals of reinforcing the competence of personnel in the field and the organization and management of community services, technical workshops were held to benefit field personnel and institutions needing reinforcement - 362 community agents were trained. The basics of community health have been conveyed to community groups and religious groups to allow them to participate productively in the provision of

services. These community groups have played a useful part in organizing communities, participating in service programs to deliver the PSPI, reaching out to target groups, and in planning and evaluation.

- Development of a Guide for Community Health Interventions based on the results of the evaluation of the delivery and quality of services offered by HS-2004 network partners in 2001 and 2002.

- Development of a *Guide d'Intervention en Santé Communautaire*. The results of the service assessments (including quality factors) carried out by MSH in 2001 and 2002 showed that most network institutions, with human capital and material and financial resources were still having difficulty developing effective community health programs to assure availability of primary health care at the community level. This situation was generally due to the weakness of the planning system, program management and implementation.

  It was necessary for the HS-2004 Project to develop the "*Guide d'Intervention en Santé Communautaire"*, which supplied the network with the orientation necessary to successfully initiate and maintain community programs that responded to the needs of the communities.

  The guide has three sections: 1) the organization, mobilization and participation of the community in program development for locally important health issues, 2) establishing and managing service programs, and 3) planning, monitoring, and evaluation.

- Following development of tools for collecting monitoring data, to support the network in improving the quality of services and motivating the service delivery staff to respect quality norms and standards, the Project produced and disseminated a series of tools to be used in collecting activity monitoring data related to case management for the target population in the various zones. These are:

  - An organizing protocol for the rally posts which contains all the essential information to prepare for and deliver services and then produce the post activity report.

  - An organizing protocol for home visits which allows the health agent to plan visits to target groups, outlines key health problems, and assures effective coverage of the population in question.

  - A register to monitor home visits including a check-list for home-based post natal care. This tool permits the community health agent to assure continuity of services, assure epidemiologic surveillance of specific diseases, and also to track new deliveries.

  - A "Cahier de poste de rassemblement" for rally posts help to strengthen weaknesses in the registry system (service data). It also serves as a tool to monitor the utilization

of services at a post and to track services offered. Finally, it helps to understand the population response to community mobilization programs.

- A standard protocol of health Agent Tasks, covering the two essential aspects of health agent activity: organization of the community, and service delivery.

- A check list for medicines and supplies (including gas for refrigeration).

- A protocol for peri-natal case management of women (to guide the service staff in provision of services from intake, through registration, consultation and provision of services).

- A protocol for case management of pregnant women and newborns related to VCT and PMTCT.

- A protocol for management of side effects related to the use of hormonal methods of family planning. The counseling and management of side effects of family planning may have had a positive impact on CPR by reducing the rate of dropouts and CPR.

HIV/TB

In cooperation with its partners, HS-2004 reviewed its previous strategy that focused on STI prevention, to include the implementation of testing and care services for affected and infected patients and for their families at both institutional and community levels, and to integrate related services, including tuberculosis. Key objectives of the revised strategy were:

Objectives

- Increase availability, access and use of child health and reproductive health services, and their integration with HIV/AIDS care.

- Strengthen the capacities to ensure HIV voluntary counseling and testing services at all the institutions of the network.

- Integrate HIV testing activities into the prenatal care program.

- Deliver adequate care (in compliance with the national norms) to affected and infected patients and to HIV+ pregnant women under the "Prevention of the Mother to Child Transmission" framework.

- Implement a functional referral and counter-referral system among the institutions' own service delivery points and other specialized institutions (for the

cases deemed more complicated) and the community programs, to facilitate the effective delivery of health care to the HIV+ individuals.

- Increase the capacities of the communities to identify their health needs and to generate demand for HIV and tuberculosis services.

- Extend tuberculosis testing and health services delivery, and their integration with HIV.

- Implement a departmental strategy for HIV/AIDS, opportunistic infections and tuberculosis, to coordinate local capacities for prevention of and delivering care for mother to child transmission.

I. Integration of HIV/AIDS services into the PSPI

The Package of Priority Services, as defined during the first phase of HS-2004, was revised in 2003 to reflect not only the importance of HIV and tuberculosis health services, but also the importance of providing them in an integrated manner, taking into account needs for equity, confidentiality, and avoiding stigma. This revised "Package of Priority Integrated Services" was adopted by all of the HS-2004 project partners. It also is being applied by other agencies and is used as a reference in discussions regarding technical assistance to the MSPP Departmental Directorates.

This Package demonstrates the need for a holistic approach to HIV health care, calling for the integration of all the other services. This integration allows for an improved cost-efficiency ratio, as well as for an improved response to the needs of the HIV infected person, of his/her family and of the community.

The areas of intervention taken into account, for all the levels of care, are:

- Reproductive health
- Child health
- STI/HIV/AIDS and opportunistic infections
- Tuberculosis
- Community approach through behavior change communication and community mobilization
- Areas of management support
- Referral system: criteria of referral from one level to the other, and the counter-referral mechanisms
- Resources needed at every level of service delivery: type, quantity based on demography, role and responsibilities of each staff category

- Material resources (supplies, equipment, commodities) which are essential for the smooth running of each service delivery point at every level

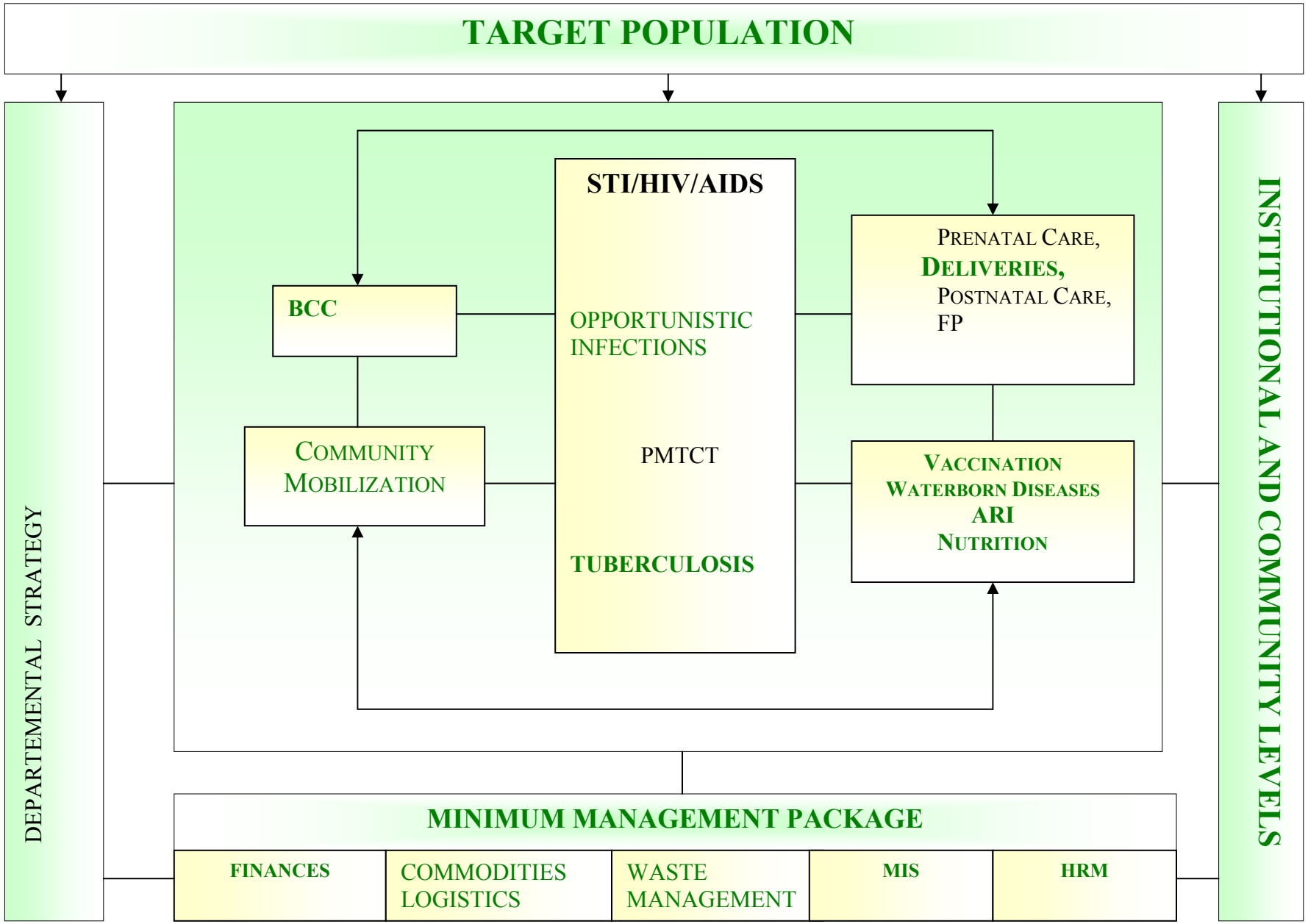
This document has been used by the Project as a guide:

- To develop the annual technical reference framework for partners drafting of strategic proposals and annual action plans
- To assess progress in implementation of the PSPI and the PMG (Paquet Minimum de Gestion)
- To make decisions and negotiate partners' strategies, plans and budgets.

It is also used as a reference:

- To justify the services and care at all levels.
- To evaluate the organization of services and quality of care based on the updated "Service Delivery and Management Assessment" tool.

GRAPHIC REPRESENTATION OF THE 2004 STRATEGY



II. Strengthen capacity needed for voluntary counseling and HIV testing at all the institutions of the Network

The opportunity for scaling up HIV/AIDS health services became a possibility with PEPFAR. As a first step, VCT services for PMTCT were implemented.

From the beginning, the HS-2004 Network provided a significant platform to the Haitian Health Sector, for the effective and rapid delivery of integrated services to contribute to implementing the national HIV/AIDS strategy. Access and availability of quality services as well as the service usage rate existing within the network's institutions represented opportunities to efficiently respond, technically and in a cost-efficient manner to meet the needs of the HIV infected person as well as of his/her family and of the community.

To successfully implement the capacities needed to provide voluntary counseling and testing services while under pressure to reach results and avoid the risks of "verticalisation", particular attention was paid to:

- Reorganization of the services and patients flow;
- Efforts aimed at complementarities and synergy;
- Development of human resources and of management systems.

After the work of defining the revised Package of Integrated Priority Services was completed, a working document was developed on the pre-requisites for the functionality of a VCT service. This document addressed needs for:

- HIV awareness of other (non-service providers) members of the institution.
- Training for all staff on infection prevention, disposal of biological products, waste management, etc.
- Information systems in compliance with the norms, respecting confidentiality and avoiding stigma
- Sound organization and inter-personal communication.
- Basic laboratory equipment.
- Continued availability and sound management of basic commodities
- Community mobilization and implementation of adapted mechanisms for the delivery of integrated care to PLWHIV at the community level.
- Direct involvement of departmental and medical directorates in program planning and execution.
- Management systems to improve the quality of services and supervision

This document is now used as both a training tool during implementation of VCT/PMTCT services, and a reference guide for providers and management personnel.

It has also served as the basis for developing the revised "Service Delivery and Assessment" protocols.

III. Development of a Coordination Model for implementation of VCT/PMTCT services

Sound and effective VCT/PMTCT services require that several technical components of service delivery and management processes be well defined and operational. In Haiti's case, the multiplicity of agencies and implementers, the availability of very significant financial resources, and the need to demonstrate tangible results in a very short time within an environment characterized by limited leadership and ineffective coordination, created serious implementation challenges and quality issues.

After several months of program implementation, considering the problems encountered particularly in the areas of service integration and quality, HS-2004 provided technical and financial assistance to the MOH to bring together all partners involved in VCT/PMTCT to review progress, identify problems and reach consensus on corrective measures.

Thus, in December 2003, as part of its support to the Coordination and Control Unit (UCC/MSPP), MSH facilitated a workshop with the following objectives:

- Assess the situation together by identifying the weaknesses and negative impacts of the interventions that were implemented without taking into account the overall framework.
- Develop a common vision, finally, of functional VCT/PMTCT services (to which anti-retroviral therapy was later added).
- Agree on mechanisms for the group's functioning, taking into account the skills and expertise of each actor.

After an honest assessment by the UCC and its partners, discussions continued regarding the identification of key technical areas needed to be operational at each site if VCT/PMTCT services were to become effective, and provided according to MOH norms. Working groups or "clusters" chaired by a Cooperating Agency (whose name is included in parenthesis below), were established for each technical area. The role of the cluster was to convene meetings and support the MOH to define the standards for that technical area and to oversee implementation.

The following clusters were created:

- Operational management and organization of services (MSH)
- Clinical and therapeutic care (FHI)
- Behavior change communication and community mobilization (JHU)
- Management information system (IHE)

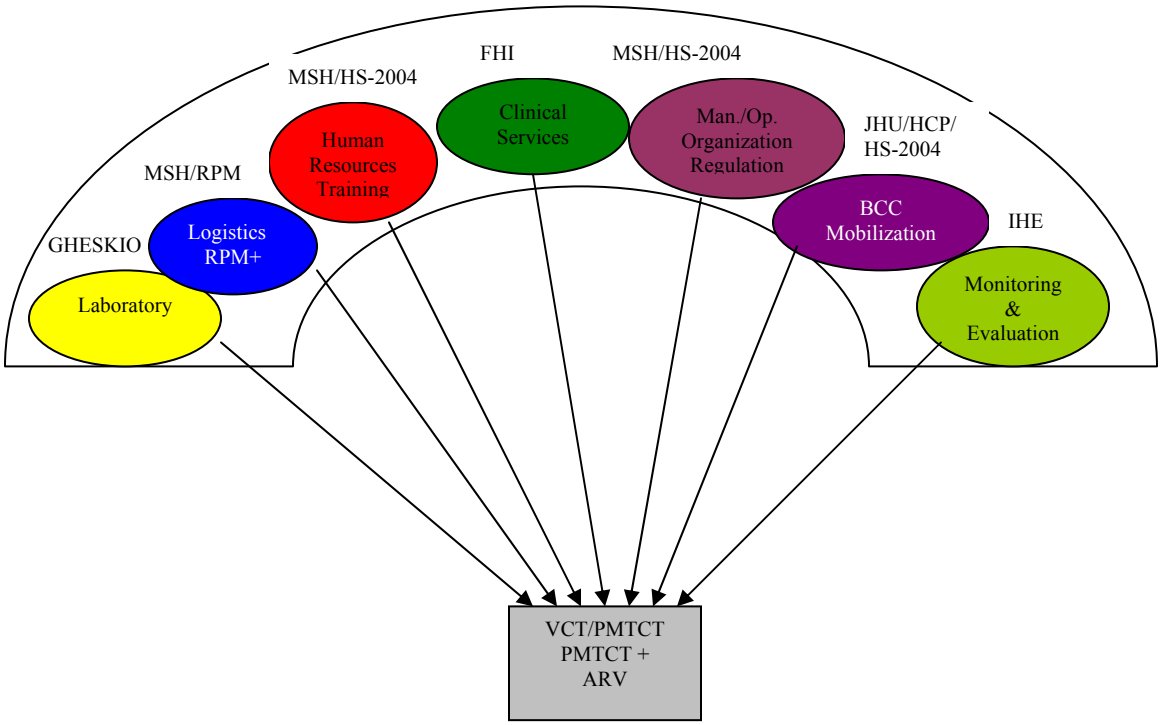
- Training (MSH)
- Commodity logistics (MSH/RPM Plus)
- Laboratory (GHESKIO)

Several subsequent meetings took place, to establish the objectives, roles and responsibilities of each cluster. The clusters did not progress at the same pace in terms of productivity, but they played an important role facilitating relationships between the actors and improve coordination. These were also essential in the discussion with PEPFAR partners regarding their mandate and work plans.

MINISTRY OF PUBLIC HEALTH AND POPULATION
CENTRAL COORDINATION UNIT
of the National Program for the Fight Against STIs and HIV/AIDS (UCC)

Governance and Coordination Model of the National Program
For the Implementation of VCT/PMTCT/ARV Services

UCC (MSH/HS-2004 support)



The fight against HIV/AIDS cannot be won without an organization of services based on a holistic approach and supported by appropriate management systems.

As part of its mandate in the "Management and Operations" cluster, HS-2004 developed an operational manual, building on lessons learned during the implementation of Voluntary Counseling and Testing services and of Prevention of Mother to Child Transmission services. This manual summarizes the important elements in service implementation and corresponds to the vision of integrated services that complies with the clinical guidelines and ethical norms recommended by the Ministry of Public Health and Population. It gives information to managers and health care providers allowing them to organize quality services by adopting uniform and standardized operational procedures at their institution.

In terms of skills improvement, an overall evaluation of the training needs was made to implement health care services for people living with HIV. In cooperation with GHESKIO, and based on the results of this evaluation, training sessions to deliver VCT/PMTCT services were conducted. By Project end, 1255 service providers have been trained, including 1126 who received VCT/PMTCT training and 92 support personnel who received supervision training to improve their capacity to provide local technical assistance at both institutional and community levels.

Material and other equipment were also provided as part of minor refurbishing and strengthening of physical infrastructures.

IV. Integration of HIV Testing activities into the prenatal program

Prenatal care is the entry point for PMTCT. Therefore, HS-2004 needed to strengthen prenatal care, at both institutional and community levels, to increase availability of and demand for services.

Based on the norms issued by the MSPP, a Practical Guide for the Delivery of Health Care to HIV+ Women was developed. This guide and accompanying worksheets were adapted in Créole for health agents and a related chapter was included in the training curriculum of TBAs.

An aggressive "Revitalisation du Programme des Matrones" was put in place to retrain TBAs, develop supply systems, increase supervision and build adequate referral mechanisms between them and the institutions. A total of 5027 community agents were trained including 1592 new TBAs, 2400 experienced TBAs and 1035 health agents. A tracking system was also implemented at institutions level for monitoring and re-supply of TBAs.

V. Delivery of adequate health care services (in compliance with national norms) to affected and infected patients and to HIV+ pregnant women under the "Prevention of the Mother to Child Transmission" framework.

In cooperation with its partners, including MSH, the Ministry of Public Health developed, and currently has, Norms for HIV Care. In support to the MSPP and more specifically to the UCC, these norms were disseminated to all the health districts in Haiti.

HS-2004 also participated in the development of the *Manuel du Conseiller pour l'assistance conseil dans le Dépistage du VIH-SIDA* (Counselor's Manual for HIV/AIDS Testing) of the Ministry of Public Health. This manual was the basis for drafting the chapter on the counseling rules within the Practical Guide for HIV+ pregnant woman, and for supervising the providers in counseling.

In addition to the training of the 1218 services providers in VCT/PMTCT services and supervision, HS-2004 visited most VTC/PMTCT sites to provide technical assistance to them based on the findings of the "SDMA" tool that was adapted and used to identify weaknesses and strengths, and to develop a corrective action plans.

VI. Launch of Anti-retroviral Therapy in four sites

In the last year of the project, a strategy similar to the one used for introducing VCT/PMTCT services in the HS-2004 Network was applied by MSH to assist four sites (CBP, GRACE CHILDREN, BERACA, MARCH) to launch anti-retroviral therapy interventions.

The implementation process included:

- Definition of the minimum required to launch the services.
- Organization of a workshop to plan for implementation, using the MSPP model of governance and coordination as a reference.
- Provision of financial and technical assistance for the implementation of the selected interventions.
- Stigma and discrimination awareness-building sessions for all staff.
- Technical assistance and training related to stigma counseling, adherence to treatment, and psychosocial support, etc.

By project's end, 107 patients are receiving anti-retroviral therapy at these centers. However major challenges remain: ensuring the continued availability of commodities, and strengthening sites laboratory capacity.

VII. Implementation of a functional referral and counter-referral system among the institution's different service delivery points, other specialized institutions (for the cases deemed complicated) and other community programs, to facilitate the delivery of effective health care to HIV+ persons.

The development of a Package of Integrated Priority Services could not by itself ensure the envisioned integration. It remains a constant, difficult and continued task. However, after so many efforts deployed during this phase of the project, so many Partners meeting to share information, so many staff awareness events, so many HIV orientation sessions, that tangible progress is noticeable in the delivery of services. Training at all levels instead of only focusing on specialized service providers seemed to be an unavoidable element. It is risky to integrate a new service within an institution, focusing only on providers, without taking into account the absolute need at all levels for awareness, orientation, and, if possible, training in the basic principles for the delivery of this service.

As soon as the VCT service implementation plan was developed, HS-2004 requested at first the participation of all key actors for better stakeholder buy-in. Orientation sessions for all staff and even simple presentations were carried out in Creole on: what is the pathology of HIV, the contamination patterns, the importance of one's status leading up to treatment, the link with other key services such as, for example, family planning and tuberculosis. These sessions were always very animated and almost invariably ended with an acceptance by the personnel and their desire to participate in HIV interventions and to support the staff providing care.

It was also important to consider referral and counter-referral under several aspects:

- Intra-institutional referrals.

- Inter-institutional referrals for the institutions belonging to the same organization.

- Inter-institutional referrals for the institutions belonging to different organizations whether private or public.

Efforts in this last area have not yet been effective due to the sensitivity regarding confidentiality.

VI. Increased capacities of communities to identify their health needs and to manage the demand for HIV and tuberculosis health services.

HS-2004 has always paid special attention to community approaches, through behavioral change communication and community mobilization.

From the beginning of its second phase, HS-2004 started organizing training sessions on the Community Action Cycle (1725 individuals were trained in the CAC). These training

sessions allowed the project to identify, together with the communities, their needs, and to prioritize them. All the institutions of the HS-2004's network received this training and duplicated it within their respective communities..

Organized community groups (115) were established in the areas served by the institutions, and these later contributed to the implementation of activities within their communities, i.e. health promotion, mobile clinics, rally posts, etc.

Support documents developed by HS-2004 in partnership with the HCP Project were used for the implementation of this component. These are:

a. Adapted community dialogue guide.
b. Inventory of community resources.
c. Summary of the quantitative survey on the quality of services.
d. Manual to "Live Positively": a guide for health care delivery at community level.
e. Guide for the implementation of community care providing programs for PLWH and PLWA in Haiti.
f. Curriculum for training social and health organizations in delivering care at the community level to HIV/AIDS affected and infected persons, including the "accompagnateurs".
g. "Accompagnateur's" profile.
h. Basic elements of the program in delivering health care services to PLWA on ARVs at the community level.
i. Practical guide for health agents, reviewed for the integration of a chapter on VCT/PMTCT.

Although initially, HS-2004 showed caution and limited its interventions for increasing demand; this prudence was largely justified. Considering the initial shortcomings of the program for increasing VCT/PMTCT services, the coordination issues mentioned earlier, and the initially low quality of services, it was critical "not to market what did not yet exist". Doing so would have been detrimental to the VCT/PMTCT Program. However, as effective services were launched and became available, HS-2004 implemented aggressive BCC/MC interventions – from "know your status to better plan your life" campaigns to promotion of services and channeling of demand.

Every time a health center was preparing to implement a voluntary counseling and testing service, a major activity was organized to mobilize or, more appropriately, to raise awareness of the population. These awareness campaigns continue through the community meetings routinely organized by community workers.

For a closer link between the institutions and the communities, particularly for the prevention of mother-to-child transmission, an orientation and awareness module was developed for TBAs and community health agents.

With the growing number of VCT/PMTCT/ART services, representatives from the private and the public sectors participated in the cascade-training sessions particularly in BCC/MC and delivering care at the community level. The following personnel were trained:

- 102 nurses
- 65 nurses aides
- 60 community agents, for the promotion of the services around the ARV sites.
- 657 other agents, on BCC/Community mobilization.
- 5027 community agents, in the promotion of VCT/PMTCT services, providing information, monitoring follow-up post-HIV test, and encouraging referrals.

These activities also resulted in the implementation of active and effective support groups around ten (10) partner institutions: St-Paul, SADA, CBP/Pignon, ICC/Grace Children, Pierre Payen, MARCH, AEDMA, CDS/Petite Place Cazeau, Marchand Dessalines.

In parallel with these community activities, awareness interventions were also conducted to promote youth responsible behavior. A media campaign to reach some 60,000 youth was conducted in six departments during popular international soccer tournaments; TV broadcast competitions and summer festivals. Interventions at schools and in the community directly reached over 10,000 youth in organized groups.

These activities were complemented by the joint efforts of the Quisqueya University and of HS-2004 for the prevention of STIs and HIV/AIDS within the university's community. This intervention contributed to meeting these youth needs to have access to accurate and quality information on STI and HIV prevention, to be oriented regarding availability and location of services and to be supported during referrals. This innovative program was highly successful and its experience should be shared with and replicated in other universities and higher-education institutions in Haiti.

Finally, in the area of palliative care, activities to educate PLWHA's families and distribute hygiene kits were delayed until the very end of the project. Because of stigmatization and confidentiality issues, it turned out to be a significant challenge to approach family members of PLWHA to educate them on best practices, when so many patients do not want their HIV-status revealed to family members. Thus, education is provided in a more overall manner, to groups, and in the waiting rooms at the clinics. Finally, for patients to take care of themselves, 2000 Life-extending Treatment (LET) kits containing basic products were bought to be distributed over the next few months while the project waits for RPM Plus to supply them.

VII. Extension of tuberculosis testing and health care services and their integration with HIV.

The objectives of the National Program against Tuberculosis (PNLT) in Haiti follow those of WHO/PAHO and the International Union against TB and Respiratory Diseases. The central Coordination Office provides leadership and overall program management. The departmental level carries out training and expansion planning along with direct supervision through field visits, and indirect supervision through quarterly departmental coordination meetings.

HS-2004 assistance to the PNLT, started in late 2000, following the MSPP decision to structure the program operationally at the departmental level with the central level playing a normative and general coordination role. Since then, HS-2004 has provided technical and financial support to the National Program in management and coordination, to departmental-level for program implementation in six departments (representing 73% of Haiti's population), and most recently, to FBO/NGO partners for integrating TB services into the PSPI provided to their populations.

HS-2004 also provided assistance to the PNLT for the re-opening of the National Lab and for the development of its successful proposal to the GFTAM ($16 million was awarded). The methodology used for the proposal development has been recognized by the GFTAM and recommended to other countries.

Despite many constraints, over the last two years, important progress was made. The cure rate of smear-positive cases moved from 48% to 70% in 2002, and of the sites offering TB services, 181 use the DOTS strategy (compared to 93 in 2000); the drop-out rate is around 7%.

In 2004, to promote coordination and synergy of HIV and TB interventions, the MOH created a super-structure to oversee and coordinate the HIV, TB and malaria programs. Subsequently, the Minister of Health requested HS-2004's technical assistance to further define this new structure's architecture and to develop its operating procedures. A senior-level working group including representatives of the MSPP, the donor community and the implementing partners was created. Several meetings took place to complete the mandate given by the Minister and recommendations were made to the MOH. However, implementation has not yet been effective as the process was seriously affected by important changes in the leadership of the HIV and the TB programs. Furthermore, the designation of an overall Coordinator by the Minister had an effect quite contrary to what was intended. Instead of improved coordination and synergy, the three programs became less effective while waiting for the Coordinator to assume her new role and for the new structure to become effective.

Despite the issues outlined above, some progress in TB-HIV integration has been made at the operational level, mostly though the Departmental Strategy launched by the Minister in June 2004. The VCT/PMTCT implementation guide was revised to include guidelines

for HIV-TB integration at service delivery level. An aggressive training program was put in place in the last few months of the project. For example, 75 laboratory technicians have been trained to do both tests in the clinics. A mapping exercise by department was developed to target HIV and TB sites targeted for service integration.

In 2004, HS-2004 also played an active role in supporting the MSPP for the definition of norms and procedures, through an enlarged working group. A change in paradigm and mentality and strong leadership from the central level will be required if the TB and HIV Programs are to reach a point of effective integration at policy and operational levels.

PEPFAR –supported Results in HS-2004 Phase 2	
Strengthening of the MSPP in terms of management at central, departmental and local levels.	➢ Operation manual developed and finalized for the organization of VCT/PMTCT. This manual has been used as the reference document for the organization of services. ➢ Development and dissemination of a practical guide and protocol for the delivery of care to HIV+ pregnant women and newborns. This guide was also adapted and used by the community agents. ➢ Development and dissemination of Logistics Management of Commodities and Financial Management. ➢ Situational analysis of the UCC describing the strengths and weaknesses, and leading to a restructuring and/or strengthening plan. ➢ Two advisors assigned to the UCC under this strengthening component (one financial advisor and one technical advisor). ➢ Dissemination of Norms for the delivery of HIV care in all the departments (interventions orchestrated by our technical advisor). ➢ Technical support to the UCC in developing and implementing the financial audit requested by the Global Fund for the activities linked to HIV. ➢ Technical assistance also provided to implement the recommendations produced by the audit. ➢ Development of integrated departmental plans including an HIV/AIDS component with both private and public partners. ➢ Technical and financial assistance for the implementation of these plans. Most of the programmed interventions were implemented. ➢ Strengthened technical capacity of the departmental directorships, by assigning a technical advisor for each of them. ➢ Development of a governance model to improve coordination of the interventions for the implementation of services aimed at providing care

PEPFAR –supported Results in HS-2004 Phase 2	
	to patients at both institutional and community level. Technical groups called "clusters" have been established to support the UCC in the following areas: Overall delivery of care, Organization of services, BCC/CM, Monitoring and Evaluation, Laboratory, Training, Commodity logistics.
Train 1500 midwives in PMTCT.	➢ Include in the practical guides for community agents a chapter on delivering VCT/PMTCT services. ➢ 4255 community agents received training or refresher courses by March 2005, as well as 1692 additional midwives, on the promotion of community-based services, in the importance of implementing a referral and counter-referral system between the two levels of care, and in monitoring and testing.
Train 500 personnel /providers at the institutional level to provide services.	➢ An overall human resources needs assessment was conducted for the delivery of STI/HIV/AIDS care; and the personnel to be trained were identified with all the targeted partners. ➢ Agreements were signed with GHESKIO to implement training activities, and by March 31, 2005, 1255 personnel and service providers were trained, including 1126 who received VCT/PMTCT training.
Increase the capacity of 12 sites to provide VCT/PMTCT services to 5300 pregnant women.	➢ More than 12 sites are providing integrated VCT/PMTCT services within the network and 26710 pregnant women were tested by March 31, 2005. ➢ 36 sites are providing VCT and PMTCT services, to date; and these sites are still receiving necessary supplies for safe deliveries. ➢ Development of a services reorganization plan per site, to ensure referrals between VCT and other services while respecting confidentiality and avoiding stigma. ➢ Formal referral systems exist between the institutional and community levels, as well as selective assistance for the availability of commodities.
Reach 60000 youth in six departments through messages of abstinence and	➢ More than 127495 youths were reached through messages on abstinence and faithfulness. ➢ 7 Non Governmental Organizations increased their

PEPFAR –supported Results in HS-2004 Phase 2	
faithfulness. Strengthen the capacities of the private partners of the network to reach at least 1500 individuals through behavior change communication messages.	knowledge in BCC, and, through peer educators, could reach more than 4795 youth, including 2240 females. ➢ A youth network (REJES) with 80 members was also established and involved in the fight against HIV/AIDS. ➢ 39 members of the REJES network received training to become peer educators. ➢ Another network with 10 members from secondary schools was also established. ➢ HIV/AIDS educational sessions were conducted for 1070 additional youths. ➢ A counseling service was implemented at the Quisqueya University, and 27 students benefited from individual therapy sessions, 20 others benefited from group therapy sessions and 48 others had informal sessions. ➢ Counseling sessions were provided through the counseling service implemented at the UNIQ. ➢ An overall training module on HIV/AIDS was introduced in the curricula at UNIQ, as well as a more specialized module on HIV/AIDS education that awards certificates.
Implement 5 VCT sites and 2 non clinical sites.	➢ The five additional sites are included in the total 36 sites offering testing services. ➢ Regarding the two non-clinical sites, several awareness- raising sessions have been held for about a hundred participants, as well as peer-training on counseling, at two offices of the drivers' association: one situated at Charéron Street and the other at Miracles Street. ➢ Implementation of awareness and mobilization activities for drivers and street merchants in the zone of the southern area bus station. *However, it should be noted that, due to the lack of security that prevails in these areas, the testing service could not be implemented.*
VCT/TB integration	➢ The "bacilloscopists" of the 71 TB sites have been

PEPFAR –supported Results in HS-2004 Phase 2	
at 65 DOTS sites (TB/HIV co-infection).	trained to perform HIV (rapid) testing. ➢ A draft protocol for the integration of the HIV/TB services was also developed. However, training is part of the integration and these efforts need to take place specifically at sites where we do not provide direct assistance for service delivery. ➢ A referral system was also formalized between the TB and HIV services of all the institutions receiving support from HS-2004, whenever both are provided.
Provide logistics support for the training of 100 clinicians and 200 social workers.	➢ Equipment and training materials have been bought in support of institutions such as I-TECH, JHU/HCP, AED/Linkages. This is also true for the procedures to obtain this support. In return, the reports from these training sessions were submitted to us to be included in our database.
Provide palliative care to 15000 infected patients, at community level. Provide home-based care (LET) to 7500 patients and their families.	➢ Development of health care services at community level, in cooperation with other partners, including HCP. ➢ 102 nurses, 65 nurse's aides, 60 health agents, 102 members of religious communities, have been trained in the promotion and importance of Voluntary Counseling and Testing. ➢ 657 health agents have been trained for Community Mobilization. ➢ 4255 community agents have also been trained in the promotion and use of VCT/PMTCT services and care delivery following testing. ➢ 115 health committees are established around institutional partners of HS-2004, and participated in providing support to PLWH. ➢ 1725 persons have been trained in community diagnosis, the identification of the priority needs of their communities, including HIV prevention and care. ➢ Training of trainers sessions have also been implemented to make these skills available department-wide.

PEPFAR –supported Results in HS-2004 Phase 2	
	➢ 2000 LET kits have also been bought for home-based care during the first quarter of 2005.
Strengthen the capacity of three pre-selected partners to provide triple therapy (CBP, GRACE and MARCH).	➢ Organization of a workshop to develop a "scaling up" plan at 4 institutions (CBP, GRACE, MARCH AND BERACA), with the participation of GHESKIO, USG Team and RPM Plus. ➢ Strengthening of the existing infrastructure, to meet the basic criteria for confidentiality and non stigmatization. ➢ Additional material and equipment provided. ➢ Training for 18 partners on ARV therapy and care to patients. ➢ Technical assistance to reorganize the services and the development of an adherence plan. ➢ Financial support for the launching of full care services. ➢ Development of a logo to identify the accredited sites, well known by the public. ➢ Strengthening of referral and counter-referral systems to increase access to services, department-wide.

HCD

The project component focusing on training and human capacity development was central to the ability of the team to build organizational capacity within the NGO/FBO network. The primary objectives were:

- Train service providers in providing quality care for all elements of the PSPI
- Train managers to be able to establish effective management systems supporting the elements of the "PMGE"(Extended Minimum Package of Management)
- Reinforce the capacity of partner institutions to plan and facilitate training programs themselves and to implement institutional training plans
- Establish a Network of Health Trainers and participate in establishing its long-term viability.
- Support the institutional development of INHSAC and other training institutions to establish them as reference institutions able to meet the training needs of HS2004 Network partners.
- Assist partner institutions to improve their human resource management systems and make available to them effective management tools
- Assist MSPP Departmental Directorates to establish training activities during the first phase of implementation of the Departmental Strategy (August- December 2004)
- Assist the "Unité de Coordination et de Contrôle (UCC)" of the "Programme National de Lutte contre les IST et le VIH/SIDA" to reinforce its role in Training coordination in priority intervention areas.
- Assure logistical arrangements for training organized by PEPFAR partners.
- Maintain a computerized training database to provide timely information necessary for making decisions.
- Furnish technical and financial assistance to "Université Quisqueya (UNIQ)" to implement its project to reach youth with HIV/AIDS information and messages.

Subject	Number of Sessions by Year					Number of Participants by Year				
	2000	2001	2002	2003	2004	2000	2001	2002	2003	2004
Child Health										
ARI		5			3		76			42
Vaccination		4	3	2			68	45	48	
Case Management for ARI/Diarrhea			3					38		
Nutrition				5					80	
Reproductive health										
Contraceptive Technology		5	3	9	9		97	37	123	168
FP Counseling					5					80
Voluntary Surgical Cont.					3					15
TOT Dissemination of FP Norms	1					26				
Dissemination of PF Norms	11					233				
ALSO – obstetrical emergencies			5					85		
Insertion/Removal of Norplant				4	4				47	44
Case management of Infectious Diseases										
Case management of HIV /AIDS		4	6	9	4		59	109	140	67
VCT/PMTCT			1	2	11			21	20	175
Counseling Assistance			4	3				16	16	
Rapid Tests			7	1				39	12	
ART					1					18
Supervision of centers for VCT/PMTCT										
Human Resource Management										
Orientation on management of Human Resources		1					45			
Supervision		1	2		1			22	40	21
TOT field supervision			1		1					25
Training of field Supervisors			4						64	
Teambuilding	1					25				
Performance Management			1					21		
Drug Logistics		5	3	8	7		71	45	136	131
TOT Waste Management					2					
Waste Management				2	14				38	346
Management Systems										
Processes of planning	2		1			43		21		
Training of Trainers (TOT)	4		1		2	68		24		43
Organization of Community Services			4					79		
Communication & Behavior Change										
Techniques of Communication				32					718	

Subject	Number of Sessions by Year					Number of Participants by Year				
	2000	2001	2002	2003	2004	2000	2001	2002	2003	2004
Total	19	25	49	77	67	395	416	602	1482	1175
Grand Total	**237**					**4070**				

Note: This table includes ONLY training programs implemented within the Project's Global Training Plan. Training activities executed in the field, in collaboration with partners are NOT included here.

Main constraints encountered

- The social crisis in Haiti has caused the loss of qualified human resources and institutions have not been able to replace them with other of same caliber. In this context, basic training remains a recurrent need.

- The loss of human resource and the continuous cycle of reassignment of human resources in the health sector have created constant need for training and reinforcement, even in areas already covered in previous sessions. This factor helps to explain the large (and increasing number of people to be trained).

- Training in new skills and innovative strategies is being established in the Network. Generally, the institutions have not had this function in the past and change is slow in spite of training and technical support furnished.

- The social and political turbulence of recent years has required changes in project HCD work plans, sometimes several times in the same year.

Lessons in the area of HCD

- The implementation of a Global Training Plan (PGF) greatly facilitates program implementation.

- Careful and detailed planning is necessary so that flexibility can be maintained and modifications made without negatively affecting implementation. For example, in 2003, numerous unforeseen activities related to VCT and PMTCT were introduced without difficulty.

- The production and distribution of work tools in generic forms (like, for example, the Generic Human Resource Management Manual) make it possible for institutions to adapt and implement faster. Enough time, however, must be allowed for adaptation, production and dissemination.

- Creation of independent groups such as the AHFS (Association of Haitian Health Trainers) makes the continuation of certain programs after the end of the project more likely.

Documents Available

- HS2004 Phase II Training Strategy
- Global Training Plan by Year (2000 - 2004)
- Generic Personnel Manuel
- Report on meetings of the Training cluster for HIV/AIDS
- Computerized database with information on partners trained by the project in phase II (by year, by institution and by subject).
- Curricula et training materials for all training programs held
- Internal rues and regulations of AHFS
- INHSAC Strategic Plan

Monitoring and Evaluation

A plan and system for setting objectives, indicators and targets, and monitoring results was established for each element of the PSPI. This Performance Planning and Monitoring (PPM) system makes possible continuous tracking of performance in service delivery and program management at both partners and project management levels. This system has been essential in timely decision making and program adjustments to ensure achievement of set objectives. It has also proven to be an important and essential component of Performance-Based Financing.

Standardization of the Service Delivery Monitoring System

To assure availability of quality data and their consistent use to monitor progress of service delivery in and across partner institutions, a field-based data collection and processing system was developed and introduced into the management systems of all partner institutions. This system, based on the MSPP national information system simplifies data collection, facilitates data processing, and promotes the use of a standard and consistent methodology for compilation and use of key indicators to monitor program evolution and progress. A set of tools was developed and training followed by tailored technical assistance was provided to all partners. The main tools of this system are:

- **A "*Guide des Variables*"** which documents the system in great details and defines all indicators and statistics to be collected and used in measuring service delivery performance. It includes operational definitions, data collection and validation methods, as well as source documents and practical methods for avoiding the most common errors.

- **Simplified Protocol for Monthly Activities Reporting.** This data collection instrument was developed to allow easy registering of service data and timely

transmission of service information within the organization and to HS-2004 Monitoring and Evaluation Unit.

- **Tableaux de Bord - TBD- (for comparison of objectives with results).** This Excel-based tool is now used by institutions (at all levels) to capture, validate, and analyze data by month and service delivery point. The electronic format makes speedy transmission of reports possible by diskette or by e-mail. The TBD includes all the elements of the PSPI included in partners contract with HS-2004.

- **Computerized Tracking System at HS-**2004: The data transmitted to HS-2004 via the TDB is entered into a computerized system that allows automatic validation using pre-programmed algorithms and timely feedback to partners. This system also provides management reports on performance by program element, by service point and by partner. These reports are used quarterly by the M&E unit to monitor performance, by the Technical Assistance team to identify technical assistance needs, and by the Contracts Office to determine contractual or performance issues to be addressed.

Establishing the health information system in the health service institutions. This goal was met by provision of appropriate tools and instruments to partners along with careful training of staff in the correct use of these resources (including computer software):

- **Provision of tools and instruments**. Service registry formats and indicator guides were made available to all partners. Information technology equipment was also provided where needed.

- **Training of personnel in HIS**. HS-2004 strengthened capacity of institutional personnel in data collection, validation, and analysis through a systematic training program with carefully developed curriculum. Part of this effort was the implementation of a Training of Trainers Program (TOT) to help institutions maintain essential skilled cadres (at least three people have been trained at each institution – the HIS manager, a field coordinator, and an agent supervisor)

- **Technical Assistance as supportive supervision** – Training activities were followed by tailored technical assistance visits

- **Mapping and denominators Update:** Digitized maps of geographic targets were prepared and target population denominators were updated using a simplified census methodology and the results of the national census.

Validation and Feedback. A series of activities were designed to promote quality of information and provide feedback to partners on both operations and service delivery performance. This program included:

  - **Technical Assistance visits (2 per year) for each SDP.** These visits include a complete review of data collection processes to (a) ensure correct use of monitoring tools, and (b) validate data received at HS-2004.

- **Feedback.** Based on reports produced by the computerized data system at HS-2004, quarterly feedback reports are sent to partners.

- **Management and quality of data.** The quality and validity of data used for issuing payments within the Performance-Based Financing Program is assessed annually by an independent local firm under contract.

The application of these measures contributed to significantly improving availability and validity of data for performance monitoring at both service delivery and at project management levels.

Documents and tools produced

- Variables and Indicators Guide
- HIS Training Program Guide
- Reports of training workshops on HIS
- Reports de supervision and Feed Back
- Methodology for the "Recensement et enregistrement des populations cibles"
- Mapping and Registration Reports
- Quarterly and annual reports
- Specific TB - TDB
- HIV/AIDS - TDB

Finance and Organizational Development

HS-2004 was charged with reinforcement of leadership and management, and promotion of organizational development of partner institutions. In working toward these goals, the project worked with the MSPP and NGO partners to define a "Paquet Minimum de Gestion Elargi" which set forth basic standards that needed to be reached by all partner institutions. These standards were in financial management, drugs and commodities logistics and management, human resource management, and waste management. The SDMA protocols introduced previously were adapted and used to evaluate management capacity of all partners. These findings were then used by partners as the basis for the development of corrective action plans, and by MSH to develop tailored technical assistance and training interventions in these areas. Technical assistance interventions were complemented by:

Development and adaptation of Generic Management Manuals - With local consultants and, in collaboration with MSPP and NGO partners, HS-2004 developed management and standard operating procedures for NGOs Financial Management, Drugs and Commodities management and Personnel Management. With technical assistance provided by the project, these tools were adapted to each partner's circumstances and level of development, and implemented within their internal management processes.

Determination of Costs for the PSPI:

In 2000 and 2001, the project gave assistance to the partners in the use of the CORE tool(Cost & Revenue Analysis Tool) developed by MSH so that it would be available to analyze service costs and provide insights to managers in the process of planning and resource allocation.

Following this initiative it was clearly necessary to provide the partners with additional mechanisms to allow adjustments in planning and cost analysis that would include factors such as transport and geographic accessibility, along with tracing of human resources needed to provide specific service elements. In a series of steps, MSH, with the assistance of several consultants, developed a costing tool that is now available to partners. It permits planning for and analysis of the costs of providing all the elements of the PSPI. It will, in the future, make possible the development of subcontract agreements based on realistic cost and pricing estimates rather than simply relying on historical records to support future plans.

Logistics of Priority drugs and commodities – departmental workshops

Drugs logistics and management was not in HS-2004's initial mandate. The lack of availability of drugs (in both public & NGO sectors) has affected quality of services and drove the process of consensus around the need for a well defined and coordinated drug logistics system.

In order to assure, in the short-term, the permanent availability of essential drugs necessary for the provision of effective health services at the peripheral level, departmental level workshops were organized to identify problems and constraints hampering the availability of drugs and commodities and to develop local plans to alleviate the situation. The workshops had as specific goals the development of departmental action plans to immediately improve the availability of drugs at service delivery level. These plans of action (LIES - *Logistique des Intrants Essentiels Subventionnés*) were finalized and validated with the health directorates and partner institutions. At the end of each workshop, a support committee, constituted of representatives of the

department and partner institutions, was put in place to, periodically, evaluate the implementation of decisions taken in the work shops.

A subsequent assessment of progress in plans implementation was done in collaboration with the Departmental Directorates. This review showed that significant progress was made at departmental level, but that more 65% of the issues and constraints faced at the departmental level could only be addressed by more supportive and responsive systems at the central level.

Lesson learned: the issues related to Drugs and Commodities will only be addressed in a sustainable manner when a locus of responsibility at a senior level is identified to (a) develop an effective procurement and distribution model for essential medicines and commodities, (b) strengthen drug management capacity for managers and service providers in the departmental depots and health facilities.

In connection with these departmental logistics plans, the HS2004 Project worked with the management committee of PROMESS. In this forum, generally presided over by the MSPP, all questions related to the availability of drugs were discussed and decision was jointly made with the affected partner institutions.

A data base tracing drug usage by partner institutions was established by the project in order to assist the institutions in avoiding and resolving stock-out problems.

The project made internet access available at the DCP/MSPP, along with information and materials to facilitate drug procurement and supply management.

Finally, a delegation of Haitian professionals from GHESKIO and DCP/MSPP were supported by the project to attend the 'Optimal Drug management for primary health care' course in Amsterdam. At the end of the course, the participants developed and distributed a proposal for the « *Renforcement du système de distribution des Médicaments Essentiels et des Intrants en Haïti* ». This document was later validated buy the MSPP and accepted by several collaborating donors.

Partners Financial Verifications:

In collaboration with its local partner, PAGS, the project complemented its financial support program to the network NGO and FBO partners by reinforcing their financial management systems to assure that all partner institutions had sound systems and complied with regulations and procedural requirements of USAID and MSH.

To that effect, a standard "Protocole de Vérification Financière" was developed, and at least once a year, each partner institution was visited. During these visits, financial management and internal control systems were evaluated. These reviews were an important element of the performance-based financing program described earlier. Each organizational review resulted in an assessment report with findings and recommendations that were shared with the organization and used in the further design of assistance plans as well as in consideration of future contract renewals. Training programs were also organized in light of weaknesses identified. These included:

- Accounting Systems,
- Management of internal receipts,
- Management of durable goods and equipment,

- Procurement of goods and services,
- Monitoring of finance and accounting systems,
- Disbursement procedures and tracking of transactions.
- Travel policies
- Budgets development and execution

Strategic Planning:

HS2004, with Group Croissance, directly financed and facilitated strategic planning workshops for: INHSAC, GHESKIO, CDS, CBP, and AOPS and then provided financial support for implementing related operational plans.

Annex I: Acronyms

List of Acronyms

BCC	Behavior Change Communication
CBP	Comité de Bienfaisance de Pignon
CDS	Centres pour le Développement et la Santé
CLM	Commodities and Logistics Management
CORE	Cost and Revenue Analysis Tool
DPEV	Direction –Programme Elargi de Vaccination
FBO	Faith-Based Organization
FOSREF	Fondation pour la Santé Reproductive et l'Education Familiale
GASCOM	Groupe d'Appui à la Santé Communautaire
GASRAM	Groupe d'Appui aux Activités de Santé de la Reproduction de l'Aire Métropolitaine de Port-au-Prince
GHESKIO	Les Centres GHESKIO
HS-2004	Haïti Santé 2004 Project
INHSAC	Institut Haïtien de Santé Communautaire
IR	Intermediate Result
M&E	Monitoring and Evaluation
MOST	Management Organizational Sustainability Tool
MSH	Management Sciences for Health
MSPP	Ministère de la Santé Publique et de la Population
NGO	Non-Governmental Organization
PAGS	Pierre André Guillaume et Associés
PBF	Performance-Based Financing
PPM	Performance Planning and Monitoring
PMTCT	Prevention of Mother to Child Transmission
TB	Tuberculosis
VCT	Voluntary Counseling and Testing